PATIENT HISTORY FORM

PATIENT'S NAME: ____ **DOB :** ____________________

REFERRED BY: ___________________________________ PURPOSE OF THE VISIT: ______________________________________

GYNECOLOGICAL HISTORY

Age of First Menstrual Period	(years)	Are You Sexually Active	☐ Yes ☐ No
No. of Days Bleeding During Period	(days)	Is Your Sexual Partner	☐ Male ☐ Female
Cycle Length (28 days or irregular)	(days)	Birth Control Method	
Last Normal Menstrual Period	(date)	Menopause	☐ Yes ☐ No
Last Pap Smear	(date)	History of Abnormal Pap	☐ Yes ☐ No

Last Mammogram: (date)	Last Dexa Scan: (date)	Last Colonoscopy: (date)

PATIENT'S PAST MEDICAL HISTORY

(mark as applicable)

		Medical condition in brief			Medical condition in brief
Cardiovascular	☐ Yes ☐ No		Infectious Disease	☐ Yes ☐ No	
Respiratory	☐ Yes ☐ No		HIV	☐ Yes ☐ No	
Thyroid	☐ Yes ☐ No		Hepatitis B	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No		Hepatitis C	☐ Yes ☐ No	
Genetic	☐ Yes ☐ No		Skin	☐ Yes ☐ No	
Psychiatry	☐ Yes ☐ No		Other (please specify)		

PAST SURGICAL HISTORY

Surgery	Reason	When

FAMILY MEDICAL HISTORY

(*Please specify if relationship is Maternal or Paternal*)

		Who?			Who?
Cancer - Breast	☐ Yes ☐ No		Diabetes	☐ Yes ☐ No	
Cancer - Colon	☐ Yes ☐ No		Heart Disease	☐ Yes ☐ No	
Cancer - Ovarian	☐ Yes ☐ No		High Blood Pressure	☐ Yes ☐ No	
Cancer - Other	☐ Yes ☐ No		Other (please specify)		

PREGNANCY DETAILS

No of Pregnancies	
Preterm Births	
Abortions	
Miscarriage / Ectopic	
Living	

Child's Birthdate MM/DD/YY	# weeks at Delivery	Birth Wt.	M or F	Type of Delivery (Vaginal or C/S)	Complications / Problems	Physician

SOCIAL HISTORY

Alcohol Use: ☐ Yes ☐ No How Much: ____

Drug Use: ☐ Yes ☐ No Which Drug(s): _____________________ How Often: _________________

Tobacco Use: ☐ Yes ☐ No How Much: ____

MEDICATIONS

Drug name	Dose	How Often	Start Date	Prescribed by

Primary Pharmacy Name ____ Phone # __________________________

Pharmacy Address: ____

ALLERGIES

Do you have any known medication allergies? ☐ Yes ☐ No If Yes, Please list:____

REVIEW OF SYSTEMS *(mark as applicable)*

Constitutional	Weight Loss, Weight Gain, Fever, Fatigue
Gynecologic	Abnormal Bleeding, Abnormal Vaginal Discharge, Painful Periods, Painful Intercourse Infertility, Fibroids, Endometriosis, Premenstrual Syndrome/PMS
Cardiovascular	Chest Pain, Difficulty Breathing, Swelling of Legs, Rapid or Irregular Heartbeat
Respiratory	Wheezing, Coughing, Shortness of Breath
Gastrointestinal	Diarrhea, Bloody Stool, Nausea, Vomiting, Constipation
Urinary Tract	Blood in Urine, Pain, Urgency, Frequency, Involuntary Loss of Urine, eg. When Coughing or Lifting
Skin	Rash, Dry Skin
Breasts	Pain, Nipple Discharge, Lumps
Neurologic	Dizziness, Seizures, Memory Problems, Headaches
Psychiatric	Depression, Anxiety, Sleep Difficulties
Endocrine	Hair Loss, Hot Flushes.

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PATIENT'S / GUARDIAN'S SIGNATURE **DATE**