

Patient History Form

Name:	Chart#:	Age:	Date:
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Primary Care Physician:	Referring Physician:
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Marital Status: Single Married Separated Widow Divorced

Reason for visit:

Gynecological History

Age period began:	Date of last menses:	Are menses regular? <input type="checkbox"/> Yes <input type="checkbox"/> No
Number of days between menses:	Number of days bleeding:	Do you have pain with periods? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> heterosexual <input type="checkbox"/> homosexual <input type="checkbox"/> bi-sexual	
Current Birth Control Method:	What other methods have you used in the past?	Heavy flow/clots? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been diagnosed with an STD? <input type="checkbox"/> Yes <input type="checkbox"/> No	What? When?	Have you been tested for HIV (AIDS)? Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Date of last pap:	Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Have you ever had an abnormal smear? <input type="checkbox"/> Yes <input type="checkbox"/> No	How was it treated?	
Date of last mammogram:	Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Date of last colon cancer screening:	Date of last bone density study:	
Have you had recent blood work to check cholesterol, glucose, and thyroid? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you had any of the following vaccines in the past 10 years? <input type="checkbox"/> Shingles vaccine <input type="checkbox"/> HPV vaccine <input type="checkbox"/> Tetanus/diphtheria vaccine <input type="checkbox"/> Hepatitis B		

Obstetric History

Total number of pregnancies: _____ Miscarriage: _____ Abortions: _____ Living Children: _____

Any complications of pregnancy or delivery?

Did you have gestational diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No	Preeclampsia? <input type="checkbox"/> Yes <input type="checkbox"/> No
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No.	Birth Date	Male/Female	Birth Weight	Type of Delivery	No.	Birth Date	Male/Female	Birth Weight	Type of Delivery
1					4				
2					5				
3					6				

Current Medications (Also include all vitamins, herbs, and any frequently used over-the-counter medications)

Drug Name:	Dosage:	Prescribed by:	Drug Name:	Dosage:	Prescribed by:

Attached Medication List

Allergies: (Drug name and reaction)			
Drug Name	Reaction	Drug Name	Reaction

Do you have a latex allergy? Yes No

Medical History			
Illness	Date	Illness	Date

Surgical History			
Surgery	Date	Surgery	Date

Social History			
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	How much?	How many years?	
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No		How many drinks in a week?	
Do you use street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No		What type and how often?	
Any history of sexual or physical abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No		What is your current occupation?	

Family History			
Father: <input type="checkbox"/> Living <input type="checkbox"/> Deceased	Cause of death:	Age of death:	
Mother: <input type="checkbox"/> Living <input type="checkbox"/> Deceased	Cause of death:	Age of death:	
<input type="checkbox"/> Family history unknown			
Is there a family history of the following? (Please list affected family members)			
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Hypertension		<input type="checkbox"/> Heart disease	
<input type="checkbox"/> High Cholesterol		<input type="checkbox"/> Blood clots in legs/lungs	
<input type="checkbox"/> Osteoporosis		<input type="checkbox"/> Breast cancer	
<input type="checkbox"/> Colon cancer		<input type="checkbox"/> Ovarian cancer	
<input type="checkbox"/> Uterine cancer		<input type="checkbox"/> Mental illness/depression	
<input type="checkbox"/> Fibroids		<input type="checkbox"/> Endometriosis	

Review of systems (Please check yes if you are currently experiencing the symptoms below)					
Symptom		Symptom		Symptom	
Weight loss/gain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation/diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Visual problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinary leakage	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Painful urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint/muscle pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression/anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hot flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hair loss	<input type="checkbox"/> Yes <input type="checkbox"/> No