PATIENT HISTORY FORM

Name: _____ Birth Date:_____

Address:_____ Phone: _____

Married Single Divorced Widowed Separated

Allergic to what medicines: _____

Medicines you are now taking: _____

MENSTRUAL HISTORY (Please describe your periods while not taking birth control?)

_____

Age your period started:_____ Regular? Yes No Cramps? Yes No

Number of days apart:_____ Number of days Flow: _____

Date of last period:_____ Menopause: Yes No When? _____

List any problems or remarks about your period:_____

Are you presently using any form of contraception? (birth control) If so, what type?

_____

Hysterectomy? Yes No If so, when?_____

OBSTETRIC HISTORY

Number of pregnancies you have had (include miscarriages)_____

Number of children born alive:_____ Number of miscarriages or abortions:_____

List any complication or remarks:_____

_____

List any surgery you have had & when (include tonsils, D&C, Tubal ligation and C-section):_____

PERSONAL

Medical Illnesses Please Circle: Thyroid Disease History of blood clots Liver disease

Diabetes Heart Disease Kidney Disease High Blood Pressure Asthma Tuberculosis

Emphysema Epilepsy or Seizures Cancer Hepatitis Other:_____

FAMILY HISTORY Please Circle & state who in your family:

Diabetes:_____ Heart Disease:_____ Kidney Disease:_____ Tuberculosis:_____

Cancer (type):_____ High Blood Pressure:_____ Asthma:_____ Emphysema: _____

Epilepsy or Seizures:_____ **Please circle: Smoker Non-Smoker**

What are you seeing the doctor for today?_____

REVIEW OF SYSTEMS: Please check the medical conditions or symptoms that apply to you:

GENERAL:

☐ Unexplained Weight Change

☐ Long-Lasting Fever

☐ Loss of Appetite

DERMATOLOGY:

☐ New or Changing Moles

☐ Skin Cancer

☐ Itching

ENDOCRINOLOGY:

☐ Excessive Thirst

☐ Excessive Urination

☐ Excessive Hunger

FEMALE REPRODUCTIVE:

☐ Pelvic Pain

☐ Abnormal Vaginal Discharge

☐ Pain with Intercourse

☐ Breast Pain

☐ Nipple Discharge

☐ Marked change in Sexual Drive

☐ Breast Lumps

☐ Abnormal Periods

☐ Heavy Bleeding

☐ Cramping

GASTROENTEROLOGY:

☐ Abdominal Pain

☐ Blood in Stool

☐ Change in Bowel Habits

☐ Bloating

HEMATOLOGY/LYMPH:

☐ Recent Swollen Glands

☐ Easy Bleeding

☐ Anemia

PSYCHIATRIC REVIEW:

☐ Depression

☐ Mood Swings

☐ Sleep Disturbance

RESPIRATORY:

☐ Chest Pain

☐ Short of Breath when you lie down

☐ Snoring

UROLOGY:

☐ Difficulty Urinating

☐ Frequent Urination

☐ Urinary Incontinence (wetting self)

☐ Frequent Bladder Infections

associates in WOMEN'S health OBGYN