***Medical History Form***

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **D.O.B**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Preferred Pronoun:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referred By**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is your General Provider?** *(Internist, Family Practitioner, PCP)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Today’s Visit: Annual Visit □ Missed Period/Positive Pregnancy Test □ GYN Problem Visit □ (Describe below)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please answer these questions about your previous and current health. Your health care provider will review these with you.*

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| **Health Maintenance Screening** |
| Last Colonoscopy: Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: Normal Abnormal  Last Bone Density: Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: Normal Abnormal  Last Mammogram: Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: Normal Abnormal  Last Pap Smear: Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: Normal Abnormal  Gardasil Injections: No Yes If Yes, how many injections? 1 2 3 Unsure  Flu Vaccine: No Yes If Yes, Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Personal/Medical History** *Please check YES if you have had any of these medical problems in the past* | | | | | |
|  | **YES** | **NO** |  | **YES** | **NO** |
| Anemia |  |  | High Blood Pressure |  |  |
| Anxiety |  |  | High Cholesterol |  |  |
| Arthritis/Joint Pain |  |  | HIV |  |  |
| Asthma |  |  | IBS (Irritable Bowel Syndrome) |  |  |
| Blood Transfusions |  |  | Incontinence |  |  |
| Blood Clots/DVT |  |  | Interstitial Cystitis |  |  |
| Blood Clotting Disorder |  |  | Kidney Disorder |  |  |
| Cancer  *If yes what type:* |  |  | Lupus |  |  |
| Crohn’s Disease |  |  | Migraines |  |  |
| Chronic Lung Disease |  |  | Multiple Sclerosis |  |  |
| Depression |  |  | Osteoporosis |  |  |
| Eating Disorder |  |  | Rheumatoid Arthritis |  |  |
| Epilepsy/Seizure Disorder |  |  | Stroke |  |  |
| Fractures |  |  | Tuberculosis (TB) |  |  |
| GERD/Acid Reflux |  |  | Thyroid Disorder: Hyper Hypo |  |  |
| Heart Disease |  |  | Ulcers |  |  |
| Hepatitis A B C |  |  | OTHER: | | |

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| **Past Gynecological History:** *Please check off any conditions that you have had and give dates if appropriate.* | | | | | | | |
|  | **YES** | **NO** | **Date** |  | **YES** | **NO** | **Date** |
| Pelvic Inflammatory Disease |  |  |  | Human Papilloma Virus (HPV) |  |  |  |
| Ovarian Cyst |  |  |  | Herpes |  |  |  |
| Fibroids |  |  |  | Gonorrhea |  |  |  |
| Endometriosis |  |  |  | Chlamydia |  |  |  |
| Breast Cancer |  |  |  | Syphilis |  |  |  |
| Fertility Problems |  |  |  | Trichomonas |  |  |  |
| Abnormal PAP Smears |  |  |  | Genital Warts |  |  |  |
| Colposcopy |  |  |  | Other: |  |  |  |
| LEEP |  |  |  | Other: |  |  |  |

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| **Menstrual History** | Date of Last Menstrual Period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Age of First Period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Your periods are: Regular Irregular  How many days are there from the start of your period to the start of your next period? \_\_\_\_\_\_\_\_\_ days  How many days your period last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ days  Menstrual Flow: Light Moderate Heavy  What Method of birth control do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Menopause** | At what age did you become menopausal? *(One year without any periods)* \_\_\_\_\_\_\_\_\_\_\_ years old |

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| **Obstetric History** | Number of Full Term Births |  |
| Number of Preterm Births |  |
| Number of Twin/Triplet Births |  |
| Number of Living Children |  |
| Number of Miscarriages |  |
| Number of Induced Abortions |  |
| Number of Ectopic Pregnancies |  |

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| **Obstetric History** | | | | | | | |
| **No.** | **Birth Date** | **# of weeks at Delivery** | **Birth Weight** | **Sex (M/F)** | **Delivery Type (Vaginal or C-Section)** | **Complications** | **Location of Delivery** |
| 1 |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |

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| **Past Surgical History** No Past Surgical History | |
| **Procedure** | **Year** |
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| **Current Medications:** *Prescription and nonprescription medicine, vitamins, home remedies, birth control pills and herbs*  No Medications | | | |
| **Medication** | **Dosage (mg)** | **Frequency** | **Prescribing Physician** |
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| **Allergies** *(Include medication, food and environmental allergies)*  Latex Iodine No Allergies | | | |
| **Source** | | **Reaction** | |
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| **Family History**  *(Please indicate below significant medical problems of family members. Indicate which family members by checking the appropriate column. Please include age at diagnosis)* | | | | | | | | | | | |
|  | **None** | **Mother** | **Father** | **Brother** | **Sister** | **Maternal G.Mother** | **Paternal G.Mother** | **Maternal G.Father** | **Paternal G.Father** | **Aunt** | **Uncle** |
| Blood Clots/DVT |  |  |  |  |  |  |  |  |  |  |  |
| Breast Cancer |  |  |  |  |  |  |  |  |  |  |  |
| Colon Cancer |  |  |  |  |  |  |  |  |  |  |  |
| Depression/Anxiety |  |  |  |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |  |  |  |  |  |
| Hypertension |  |  |  |  |  |  |  |  |  |  |  |
| Ovarian Cancer |  |  |  |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |  |  |  |
| Uterine Cancer |  |  |  |  |  |  |  |  |  |  |  |
| Other Cancers |  |  |  |  |  |  |  |  |  |  |  |
| Other Diseases |  |  |  |  |  |  |  |  |  |  |  |

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| **Genetic Testing** *(Have you or a family member been tested for any of the following?* | | | |
|  | **YES** | **NO** | **If Yes, Result and Who was Tested** |
| BRCA |  |  |  |
| Myriad MyRisk |  |  |  |

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| **Social History** | |
| Occupation | What is your current occupation? |
| Sexual Activity | Are you Sexually Active? Yes No Not Currently Never  Current Sexual Partner (s) is/are: Male Female Both  Have you had more than 5 sexual partners in your lifetime? Yes No |
| Alcohol Use | Yes No Social Drinker Drinks per week: \_\_\_\_\_\_\_\_\_\_  Is your alcohol use a concern to yourself or others? Yes No |
| Drug Use | Do you use recreational drugs? Yes No  Have you ever used needles? Yes No |
| Tobacco Use | Cigarette Use: Yes No Occasional Smoker Former Smoker  E-Cigarette Use: Yes No  Current Smoker: Packs per day \_\_\_\_\_\_\_\_\_\_ Number of years smoked: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Safety | Is violence at home a concern for you? Yes No  Have you ever been a victim of abuse or intimate partner violence? Yes No |
| Lifestyle | Do you drink milk or eat dairy products daily? Yes No  Do you take Calcium supplements? Yes No  Do you exercise? Yes No If yes, number of times per week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please list any other health information you would like to discuss:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**