

NAME: _____

DOB: _____

MEDICAL HISTORY

Age of first menstrual period: _____ How often do you have your period: _____

How would you describe your period? Light Mild Heavy Do you have pain with periods? Yes No

Vaginal Infections? Yeast Trichomonas Other _____

Date of last menstrual period: _____ Length: _____

Date of last Pap smear: _____ Results: _____

Date of last mammogram: _____ Results: _____

Urinary problems: Urgency Frequency Pain during urination Loss of urine when coughing, sneezing or laughing

Other problems: Pelvic pain Irregular Vaginal bleeding Abnormal Pap Smears Infertility Pelvic infections

Recent unexplained weight loss Weight gain No Yes How much? _____

Cough for more than 3 weeks: · No · Yes **Fever:** · No · Yes **Coughing blood:** · No · Yes **Night Sweats:** · No · Yes

Sexual History: Age when sexual activity began _____ Number of current partners _____ Total number of partners _____

Pain with intercourse Satisfied Sexual Dysfunction Contraceptive Method _____

	Do you or have you ever had any of the following conditions?		Does anyone in your family have any of the following conditions?	
	Yes	No	Yes	No
Bleeding Problem				
Cancer				
Diabetes				
Genetic Disorder				
Heart Problem				
Hepatitis				
High Blood Pressure				
Lung Problem				
Muscle/Bone Musculoskeletal problem				
Neurological Problem				
Emotional Problems				
Stomach/Bowel Problem				
Thyroid Problem				

Food/Drug Allergies: _____ **Current Medications:** _____

What subject do you need more information on? Diagnosis/Condition/Treatment Medications/Pain Management Other _____

How do you learn best? Demonstration Verbal Explanation Audio/Visual Printed Material Groups

Hospitalization or Surgeries

Please list any past surgeries or hospitalization, include date and name of hospital.

Pregnancy History-Past Pregnancies

	Date Mo/Yr	GA Weeks	Length of Labor	Birth Weight	Sex M/F	Type of Delivery	Anesthesia	Place of Delivery	Preterm Labor Yes/No	Comments/Complications
1										
2										
3										
4										
5										

OFFICE USE ONLY

Date Reviewed: _____

Signature: _____