Minnesota Women's Care P.A.
OBGYN & SPECIALTY CARE CENTER

Patient Medical History Form

Name_________________________ Date of Birth____/____/____ Today's Date: ______________________

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Referred By: ______________________

First day of last menstrual period: ______________________

Medical History: Have you ever had any of the following?

☐ Anemia
☐ Abnormal pap
☐ Bleeding Problems
☐ Stroke
☐ High Cholesterol
☐ Mitral Valve Prolapse
☐ Heart Disease/Attack
☐ High Blood Pressure
☐ Blood Clots in Lungs/Legs
☐ Gall Bladder Disease
☐ Liver Disease/Hepatitis
☐ Kidney Infections
☐ Bladder Infections
☐ Pelvic Infections
☐ Arthritis
☐ Chicken Pox
☐ Epilepsy/Seizures
☐ Migraines
☐ Depression/Anxiety
☐ Drug or Alcohol Problem
☐ Diabetes
☐ Asthma
☐ Pneumonia
☐ Tuberculosis
☐ Sickle Cell Disease
☐ Thyroid Problem
☐ Blood Transfusion
☐ Genetic Condition
☐ Cancer

List all medications you are currently taking, including over-the-counter medications, vitamins and herbal remedies:

______________________ ______________________ ______________________
______________________ ______________________ ______________________

List any allergies to medications: ______________________ ☐ No Known Allergies

Surgical History: Please list all surgeries with dates.

______________________ ______________________
______________________ ______________________

Obstetrical History:
☐ Check here if you have **never** been pregnant ☐ Check here if you have adopted children and list names below
Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopics (tubal), and abortions:

Year	M/F	Weight	Type of Delivery	Length of Pregnancy	Problems (e.g., preterm labor, diabetes, high blood pressure)	Name/Age

Gynecology History:
Age of first period: _____
Age of last period: _____
Days between periods: _____
Length of period: _____ days

Periods are:
☐ Regular
☐ Irregular
☐ Painful
☐ Not really bothersome

Flow is:
☐ Light
☐ Light to moderate
☐ Moderate to heavy
☐ Very heavy

Are you sexually active:
☐ Yes
☐ No
☐ Virginal

Sexual preference:
☐ Heterosexual
☐ Homosexual
☐ Bisexual

New partners: ☐ Yes ☐ No
Number of lifetime partners ______

Method of Birth Control:
☐ Condoms
☐ Tubal/Essure
☐ None
☐ Vaginal ring
☐ IUD
☐ Other______________________
☐ Partner with vasectomy
☐ Natural family planning
☐ Pills
☐ Patch

Have you ever had any of the following STDs:

☐ Chlamydia
☐ HPV
☐ HIV
☐ Hepatitis C
☐ Gonorrhea
☐ Herpes
☐ Syphilis
☐ Trichomonas
☐ Hepatitis B
☐ None

Date of last pap smear: ___________

☐ Normal
☐ Abnormal

Have you ever needed any of the following for an abnormal pap:

☐ Colposcopy
☐ Cryosurgery
☐ LEEP/Laser/Conization
☐ No

Have you ever had any of the following:

☐ Fibrocystic breasts
☐ Ovarian cysts
☐ Endometriosis
☐ Uterine fibroids

Date of last mammogram: _________

Mammogram Results:

☐ Normal
☐ Abnormal
☐ Never had one

Date of last bone density: _________

Bone Density Results:

☐ Normal
☐ Osteopenia
☐ Osteoporosis
☐ Never had one

Date of last colonoscopy: _________

☐ Never had one

Family History:

Please list any close relatives with a history of the following:

	Relationship:	Age at Diagnosis:
Breast Cancer		
Ovarian Cancer		
Uterine Cancer		
Colon Cancer		
High Blood Pressure		
Diabetes		
Heart Disease (Heart Attack, Stroke, Bypass Surgery)		

Social History:

Alcohol Use ☐ Yes ☐ No If yes, _________ drink(s) per day/week/month

Tobacco Use ☐ Yes ☐ No If yes, _________ pack(s) per day for _________ years

Street Drug Use ☐ Yes ☐ No Type and frequency: ___________________________________

Exercise ☐ Yes ☐ No Type and frequency: ___________________________________

Caffeine ☐ Yes ☐ No If yes, _________ drink(s) (coffee, tea, soda) per day/week

Sexual Abuse ☐ Yes ☐ No If yes, are you safe now? ☐ Yes ☐ No

Sexual Abuse counseling? ☐ Yes ☐ No

Physical Abuse ☐ Yes ☐ No If yes, are you safe now? ☐ Yes ☐ No

Physical Abuse counseling? ☐ Yes ☐ No

Emotional Abuse ☐ Yes ☐ No If yes, are you safe now? ☐ Yes ☐ No

Emotional Abuse counseling? ☐ Yes ☐ No

Review of Systems:

Do you currently have any of the following: Comments

Generally Healthy:	☐ Yes	☐ No	________________
Frequent Urination:	☐ Yes	☐ No	________________
Recent weight gain/lose 25+ lbs:	☐ Yes	☐ No	________________
Burning Urination:	☐ Yes	☐ No	________________
Fever:	☐ Yes	☐ No	________________
Incontinence:	☐ Yes	☐ No	________________
Vision Problems (excluding glasses):	☐ Yes	☐ No	________________
Urgency:	☐ Yes	☐ No	________________
Sinus Problems:	☐ Yes	☐ No	________________
Bladder Infection:	☐ Yes	☐ No	________________
Hearing Loss:	☐ Yes	☐ No	________________
Vaginal Discharge:	☐ Yes	☐ No	________________
Chest Pain:	☐ Yes	☐ No	________________
Irregular Vaginal Bleeding:	☐ Yes	☐ No	________________
Varicose Veins:	☐ Yes	☐ No	________________
Pelvic Pain:	☐ Yes	☐ No	________________
Shortness of Breath:	☐ Yes	☐ No	________________
Painful Intercourse:	☐ Yes	☐ No	________________
Chronic Cough:	☐ Yes	☐ No	________________
Breast Lumps:	☐ Yes	☐ No	________________
Diarrhea:	☐ Yes	☐ No	________________
Back Pain:	☐ Yes	☐ No	________________
Constipation:	☐ Yes	☐ No	________________
Joint/Muscle Pain:	☐ Yes	☐ No	________________
Blood in Stools:	☐ Yes	☐ No	________________
Depression/Anxiety:	☐ Yes	☐ No	________________
Heartburn/Reflux:	☐ Yes	☐ No	________________

Patient Signature: ______________________________ Date: ________________

Clinician Signature: ______________________________ Date: ________________