Patient Medical History Form

Legal Name:_____ Date of Birth:____/____/____ Today's Date:____/____/____

Preferred Name:_____ Preferred Pronouns:_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed Referred By_____

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
- ☐ Chicken Pox
- ☐ Epilepsy/Seizures
- ☐ Migraines
- ☐ Depression/Anxiety
- ☐ Drugs or Alcohol Problems
- ☐ Diabetes
- ☐ Gall Bladder Disease
- ☐ Liver Disease/Hepatitis
- ☐ Heart Disease/Attack
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sickle Cell Disease
- ☐ Thyroid Problem
- ☐ Blood Transfusion
- ☐ Genetic Condition
- ☐ Cancer
- ☐ Kidney Infections
- ☐ Bladder Infections
- ☐ Endometriosis
- ☐ Ovarian Cysts
- ☐ Uterine Fibroids
- ☐ Fibrocystic Breast
- ☐ Pelvic Infections
- ☐ Arthritis
- ☐ Asthma
- ☐ Other

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.

_____ _____

_____ _____

Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopics (tubal), and abortions

Year	M/F	Weight	Type of Delivery	Problems (e.g., preterm, diabetes, high blood pressure)	Names/Ages

Gynecology History:

Age of first menstrual period:_____

Last menstrual 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
- ☐ Never Been

Partners:

- ☐ Male
- ☐ Female
- ☐ Both

Method of Birth Control:

- ☐ Condoms
- ☐ Vaginal Ring
- ☐ Partner with vasectomy
- ☐ Pills
- ☐ None
- ☐ Tubal/Essure
- ☐ IUD
- ☐ Natural Family Planning
- ☐ Patch
- ☐ Other _____

Have you ever had any of the following STDs:

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

Preventative Care:

Date of last mammogram:_____ ☐ Normal ☐ Abnormal

Date of last Pap Smear :_____ ☐ Normal ☐ Abnormal

Date of last Bone Density Scan:_____ ☐ Normal ☐ Abnormal

Date of last Colonoscopy or Cologuard:_____ ☐ Normal ☐ Abnormal

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

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

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

Diagnosis:	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, _____ packs(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
Any History of Abuse?	☐ Yes	☐ No	