Date: _____

Patient Medical History

Name: _____

Date of Birth: _____

Primary Care Physician: _____ Referring Physician: _____

Reason For Today's Exam: _____

Date Of Last Gynecologic Exam: _____ Was A Pap Smear Done? Y N

Obstetric History

	number		number		number
Pregnancies		Live Births		Living Children	
Premature Births (<37wks)		Miscarriages		Abortions	

No.	Year	Birth Weight	Sex	Weeks Pregnant	Type of Delivery	Complications
1						
2						
3						
4						

Current Medications

Drug Name	Dosage	Who Prescribed

Drug Name	Dosage	Who Prescribed?

Menstrual History / Gyn History

Age of Onset		Days of Flow	
Days in Cycle		Regular Cycles?	Y N

Birth Control Method			
Age At Menopause			
Date Of Last Mammogram			
result			
Previous Breast Biopsy		Y	N

Drug Allergies

Drug	Reaction

Social History

		amount	
Tobacco Use	Y		N
Alcohol Use	Y		N
Recreational Drug Use	Y		N

Surgical History

Date	Surgical Procedure	Surgeon

Personal and Family History

	yes	family member/self
Breast Cancer		
Colon Cancer		
Uterine Cancer		
Ovarian Cancer		
Cancer (Other Locations)		
Asthma		
Lung Problem		
Diabetes		
High Blood Pressure		
Stroke / TIA		
Blood Clots (Leg/Lung)		
STD's		
Infertility		
Heart Disease		

	yes	family member/self
Thyroid Disease		
Autoimmune Disorder		
Kidney Problems		
Osteoporosis		
Bowel Problems		
Hepatitis		
Reflux / Hiatal Hernia		
Depression / Anxiety		
Seizure / Epilepsy		
Alcohol / Drug Abuse		
Eating Disorder		
Blood Transfusion		
Glaucoma		