Patient Medical History

Name: _____ Age: _____

Do you have any medical problems? □ No □ Yes
(Example: Heart disease, high blood pressure, asthma, high cholesterol, diabetes)
Please List: _____

_____

_____

Are you taking any medications? □ No □ Yes
(Please include anything you buy over the counter and herbal medications)

Drug Name	Dosage	Who Prescribed

Have you ever had surgery or been hospitalized? □ No □ Yes

Reason	Date	Hospital

Are you allergic to anything? □ No □ Yes
List allergy and type of reaction:

_____

_____

Patient Medical History

Are there any medical problems that run in your family? □ No □ Yes

List: _____

_____

Social History

Ever smoked? □ No □ Yes _____ years. Current smoking: _____ packs per day.
Do you drink alcohol □ No □ Yes How much:
Drug use: □ No □ Yes Type:
Marital Status: □ Single □ Married □ Widowed □ Divorced □ Living with Partner
Current or most recent job:

Obstetric History

Have you ever been pregnant? □ No □ Yes (complete boxes below)

Total pregnancies:	Living Children:	Miscarriages:
Abortions:	Premature births:	Cesarean sections:

Gynecologic History

Have you ever had an abnormal pap smear? □ No □ Yes

When was your last pap smear? _____

Have you ever had a lump in your breast or other breast problem? □ No □ Yes

List: _____

Have you ever had a sexually transmitted disease? □ No □ Yes _____

Are you postmenopausal? (Have you stopped having periods?)

□ Yes

When was your last period (age)? _____

□ No

How old were you when you had your first period? _____

Length of periods (number of bleeding days?) _____

Number of days between periods _____

Present method of birth control _____