PATIENT HISTORY INFORMATION

Name _____ Date of Birth _____ Today's Date_____

YOUR PAST MEDICAL HISTORY
(Circle any that may apply)

Abnormal Bleeding	Glaucoma
Anemia	Hypertension
Anxiety/Depression	Intestinal Disorders
Asthma	Migraines
Blood Transfusion	Pelvic Pain
Cardiovascular Disease	Sexual Assault
Cervical Dysplasia	Stroke
Clotting Disorder	Seizures
Diabetes	Thyroid Disorder
Endometriosis	Traumatic Injury
Esophageal Reflux	Varicosities

Please list any other injury/illness:

_____
_____
_____

Have you ever had CANCER? _____
*If yes, when?*_____
Type? _____

SURGICAL HISTORY
Have you ever had surgery?_____
If yes, list below:
Date Surgery Problems

_____
_____
_____
_____

ALLERGIES

_____
_____
_____
_____
_____

CURRENT MEDICATIONS

_____
_____
_____
_____
_____
_____
_____

FAMILY HEALTH HISTORY
(Circle any that may apply)

Breast Cancer	Diabetes
Cardiovascular Disease	Ovarian Cancer
Clotting Disorders	Thyroid Disorder
Colon Cancer	Uterine Cancer

Other: _____

REPRODUCTIVE HISTORY
Last Menstrual Period: _____
Method of Contraception: _____
Do you desire contraception? Yes_____ No_____
Total Pregnancies_____ Full Term_____
Pre-Term (under 38 weeks) _____ Abortions____
Miscarriages_____ Ectopic_____ Stillborn_____
C-Section _____ Current living children _____
Problems during previous pregnancies (check):
Hypertension____ Diabetes _____ Toxemia _____
Pre-Term Labor _____ Excessive Blood Loss _____
Blood Transfusion _____

GENERAL HEALTH
Alcohol Use: (*circle answer)*
Never Rarely Occasionally Moderately
Tobacco Use: *(circle answer)*
Never Former Current Packs per day:_____
Date of last Pap Smear: _____
Date of last Mammogram: _____
Date of last Colonoscopy: _____
Date of last Bone Density: _____