

PATIENT HISTORY FORM (Please Print)

Office Use Only: ID:

Last Name:

First Name:

Primary Care Doctor:

Reason for visit:

Annual

Problem

MENSTRUAL HISTORY

Last Menstrual Period: /

Age at 1st Menstrual Period: /

Frequency: # Weeks: or # Days:

Amount: light normal heavy

Irregular: (check)

Menopause:

Method of Birth Control (check one)

Abstinence DepoProvera Oral contraceptives

Condoms Early Withdrawal Tubal Ligation/Vasectomy

Contraceptive Patch/ring IUD Other None

MEDICAL/FAMILY HISTORY

Check problems you (P) or your family (F) have or had:

- Grid for Medical/Family History with columns P and F for various conditions like Anemia, Arthritis, Asthma, etc.

SEXUAL HISTORY

Age of first sexual Intercourse: < 18 yrs old > 18 yrs old

of sexual partners: 3 or less 4 or more

Sexual activity: Never Females Males Both

GYNECOLOGIC HISTORY (Month/year)

Last pap smear: /

Last Mammogram: /

Check problems you have or had:

- Grid for Gynecologic History with conditions like Abnormal pap smears, Infertility, Endometriosis, etc.

OBSTETRICAL HISTORY (List number of pregnancies)

Preterm Vag Deliveries # Preterm C-Sect Deliveries # Miscarriages

Full term Vag Deliveries # Full term C-Sect Deliveries # Elective Terminations

SURGICAL HISTORY Check all that apply:

Appendectomy Gall Bladder Tonsillectomy

D & C Hysterectomy Other

MEDICATIONS

None Blood Pressure Hormones

Anti-Depressant Diabetes Thyroid

Contraceptive Heart Other

DRUG ALLERGIES

None Penicillin Other

Codeine Shellfish

SOCIAL HISTORY

Status: Married Single Divorced Widow

Employed: Yes No

Cigarettes per day: Substance Abuse (Check if Yes)

Alcohol drinks per wk: Seatbelt use

Exercise: Yes No Physical/Sexual Abuse

CURRENT/PREVIOUS MEDICAL CONCERNS

(check all that apply; (C) Current (P) Previous)

- Grid for Current/Previous Medical Concerns with columns C and P for conditions like Weight change, Bleeding between periods, Fever/chills, etc.