

# PATIENT HISTORY

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
Reason for visit: \_\_\_\_\_

\*For staff use only \*

When was the first day of your last menstrual period (LMP)? \_\_\_\_\_

**Obstetrical History:** Total number of pregnancies \_\_\_\_\_  
Total number of births \_\_\_\_\_  
Total number of pregnancy losses or terminations \_\_\_\_\_

When was your last pap smear? \_\_\_\_\_

When was your last mammogram? \_\_\_\_\_

**Gynecological History:** Check if you have or have had any of the following:

<input type="checkbox"/> Fibroids	<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Ovarian cysts	<input type="checkbox"/> Breast cancer
<input type="checkbox"/> Abn. Vag. Bleeding	<input type="checkbox"/> Infertility
<input type="checkbox"/> Pelvic pain	<input type="checkbox"/> Cervical cancer
<input type="checkbox"/> Bladder infections	<input type="checkbox"/> Incontinence (loss of urine)

How often do your periods come? \_\_\_\_\_ How long do they last? \_\_\_\_\_

Do you have cramps? Y/N How bad are they? \_\_\_\_\_

How many pads/tampons do you use in a day? \_\_\_\_\_

What was your age at first menses? \_\_\_\_\_

Have you had a sexually transmitted infection? Y/N If so, what? \_\_\_\_\_

Have you have abnormal paps? Y/N If so, when? \_\_\_\_\_

What birth control have you used in the past? \_\_\_\_\_

Have you had a colposcopy Y/N If so, when? \_\_\_\_\_

Have you had an endometrial biopsy? Y/N If so, when? \_\_\_\_\_

Present health status? \_\_\_\_\_ Any problems? \_\_\_\_\_

Recent medical care? Y/N If so, Why? \_\_\_\_\_

## Personal & Past History:

<input type="checkbox"/> Heart disease	<input type="checkbox"/> Kidney/bladder disease
<input type="checkbox"/> Mitral valve prolapsed	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Neurological disease (cerebral palsy, Lou Gehrig's)	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Psychiatric illness	<input type="checkbox"/> Phlebitis (blood clots)
<input type="checkbox"/> Lung disease (emphysema, chronic lung disease)	<input type="checkbox"/> Asthma
<input type="checkbox"/> Liver disease (cirrhosis, jaundice)	<input type="checkbox"/> Stroke
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Infertility	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Blood disease (hemophilia, anemia)	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Gastrointestinal disease (diverticulitis, crohn's)	<input type="checkbox"/> Cancer
<input type="checkbox"/> Birth defects/handicaps	<input type="checkbox"/> Chicken pox
<input type="checkbox"/> German measles	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Polio	<input type="checkbox"/> Cooper allergy
<input type="checkbox"/> Wilson's disease	<input type="checkbox"/> Mumps
<input type="checkbox"/> Elevated cholesterol	<input type="checkbox"/> Other

**Surgical History:** List all surgeries, hospitalizations, and blood transfusions