



Medical History

Name _____ DOB _____ Date _____

Main reason for office visit _____

Allergies _____

Primary Care Physician (PCP) _____

PCP Address _____ PCP Phone _____

Pharmacy Name (cross streets) _____ Pharmacy Phone _____

Please completely fill out this section

GYNECOLOGICAL HISTORY

MENSTRUAL PERIODS

First day of last period _____

Age when you started _____

How many days do you flow? _____

Menstrual cycle length _____

(Length of time from the first day of your period to the start of your next period)

Which of the following apply to you? (Past or Present)

Painful periods _____

Bleeding between periods _____

Irregular periods _____

PAP SMEAR

Date of last one _____

Where was it done? _____

History of abnormal Pap _____

BIRTH CONTROL

Current Method _____

Previous method(s) _____

LAST MAMMOGRAM _____

SEXUALLY TRANSMITTED INFECTION (date)

Chlamydia _____

Gonorrhea _____

PID _____

HIV _____

Hepatitis B _____

Hepatitis C _____

Genital warts _____

Herpes _____

SEXUALITY

Number of present partners _____

Male, Female, or both (circle the one that applies to you)

Painful intercourse Y N

Decreased Sexual interest Y N

DES daughter? _____

REVIEW OF SYSTEMS Are you having any of the following problems **TODAY?**

	Yes	No
Heart Trouble		
Heart Murmurs		
Rheumatic Fever		
Blood Clots (Legs or Lungs)		
High Blood Pressure		
Anemia		
Blood Transfusion		
Elevated Cholesterol		
Chest Pains		
Pneumonia		
TB or Valley Fever		
Gallbladder Problems		
Yellow Jaundice (hepatitis)		
Ulcers		
Bloody Stools or Vomit		
Bowel Habit Changes		
Colitis or Spastic Colon		

	Yes	No
Kidney Infection		
Bladder Infection		
Blood in Urine		
Involuntary urine loss		
Frequent Headaches		
Fainting Spells		
Convulsions		
Thyroid Problems		
Diabetes		
Recent Weight Change		
Breast Problems		
Feeling that pelvic organs are falling out		
Cancer		
Depression		
Psychiatric Care		
Bone Problems		
Muscle Problems		



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Non physician Fees*

Missed appt without 24 hours notice		\$75
Missed surgery without 48 hours notice		\$250
FMLA (per employer)		\$35
Records request		
to MD office for continuing care		No charge
all other	<50 pages	\$45
	>50 pages	+ \$20 for each additional 15 pages
Prescription Refills		No Charge with 72 hours notice

Initials _____

Remember to allow 10 business days for completion of FMLA and medical records preparation and 3 business days for prescription refills. All other requests are considered rush requests and have a \$50 charge. * These fees are your responsibility and are not covered by insurance.

NEW PATIENTS completely fill out this section

ESTABLISHED PATIENTS for each section below, note new events in the last year or indicate no change

OBSTETRIC HISTORY (include ALL miscarriages, abortions and ectopic)

Birth date	c/s or vaginal	# wks at delivery	Birth wt.	Sex	Hospital	Complications

ACCIDENTS AND SAFETY

Abuse/Violence at home	Y	N
Seatbelt use	Y	N
Bike Helmet use	Y	N
Up to date for routine vaccinations	Y	N

MEDICAL HISTORY (check all that apply)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypercholesterolemia (high cholesterol)
<input type="checkbox"/> DVT/PE	<input type="checkbox"/> Hypertension (high blood pressure)
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Hyperthyroid (thyroid function too high)
<input type="checkbox"/> Fibroids (leiomyoma)	<input type="checkbox"/> Hypothyroid (thyroid function too low)
<input type="checkbox"/> GERD	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart Attack	Other (Please Specify) _____

PREVIOUS SURGERY/HOSPITALIZATIONS (NOT including childbirth)

Year	Surgery	Hospital



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HABITS

	Current		Past		How much (now or in the past. Quit Date?)
	Yes	No	Yes	No	
Tobacco use					
Alcohol use					
Injection drug use					
Other drug use (specify drug name)					
Caffeine use					
Exercise (specify type of exercise)					

MEDICATIONS (if none please write NONE)

Medications (Name and dose)	Vitamins/Herbs/Nutritional Supplements

FAMILY HISTORY

(If known, specify which relative and whether on mother or father's side)

Condition	Affected relative	Mother's side	Father's side
Cardiomyopathy			
Colon Cancer			
Congestive Heart Failure			
Diabetes			
Breast Cancer (age at diagnosis)			
Heart Attack			
High Blood Pressure			
Ovarian Cancer			
Other Medical Problems			

Signature