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)

PAP SMEAR
Date of last one_____
Where was it done?_____
History of abnormal Pap_____

LAST MAMMOGRAM_____

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

Which of the following apply to you? (Past or Present)
Painful periods_____
Bleeding between periods_____
Irregular periods_____

BIRTH CONTROL
Current Method_____
Previous method(s)_____

SEXUALLY TRANSMITTED INFECTION (date)
Chlamydia_____
Gonorrhea_____
PID_____
HIV_____
Hepatitis B_____
Hepatitis C_____
Genital warts_____
Herpes_____

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		

Medical History

Name_____ DOB_____ Date_____

Non physician Fees*

Missed appt without 24 hours notice		$75
Missed surgery without 48 hours notice		$250
FMLA (per employer)		$50
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**
Advanced directive/Living will	**Y**	**N**

MEDICAL HISTORY (check all that apply)

_____Diabetes
_____DVT/PE
_____Endometriosis
_____Fibroids (leiomyoma)
_____GERD
_____Heart Attack
_____Hypercholesterolemia (high cholesterol)
_____Hypertension (high blood pressure)
_____Hyperthyroid (thyroid function too high)
_____Hypothyroid (thyroid function too low)
_____Stroke
Other (Please Specify)_____

PREVIOUS SURGERY/HOSPITALIZATIONS (**NOT** including childbirth)

Year Surgery Hospital

_____

_____

_____

Medical History

Name_____ DOB_____ Date_____

HABITS

	Current		Past		
	Yes	No	Yes	No	How much (now or in the past. Quit Date?)
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