Past Medical and Surgical History

Name: _____ Date: _____

Personal History:

Birth date: _____
Marital Status: _____
Patient Occupation: _____
Spouse Occupation: _____
Avg Exercise per week: _____
Alcohol (amt/day): _____
Illicit drugs: _____
Tobacco (amt/day): _____
Caffeine (amt/day): _____

Children	Age/Health
1. _____	_____
2. _____	_____
3. _____	_____

Medications

Medicine	Reason	Dose
_____		
_____		
_____		

Medication Allergies

Medicine	Reaction
_____	
_____	

Gynecological/Obstetrical

Sexually active: Y N
Method of contraception: _____
Date of last period: _____
Interval between periods: _____ days
Duration of period: _____ days
Flow: light normal heavy
Pain with periods: _____
Duration of pain: _____
Pain with intercourse: _____
Lack of sex drive: _____
Started menstruating at age: _____
Date of last Pap test: _____
# of pregnancies: _____
# of births: _____ miscarriages: _____
History of abnormal Pap:_____
History of sexually transmitted diseases:
_____
History of vaginal infections: _____
Last mammogram: _____
Breast lumps/discharge: _____

Past Medical History

Bladder or kidney infection	Y	N
Hepatitis	Y	N
Blood transfusion	Y	N
Bleeding disorder	Y	N
Anemia	Y	N
Thyroid disorder	Y	N
Diabetes	Y	N
Asthma	Y	N
Heart disease	Y	N
High blood pressure	Y	N
Rheumatic fever	Y	N
Tuberculosis/exposure to TB	Y	N
Cancer	Y	N
Mental illness	Y	N
Other: _____	Y	N

Surgeries/Operations

_____
_____
_____

Family History	(if yes what relation)		
Bleeding disorder	Y	N	_____
Heart disease	Y	N	_____
Osteoporosis	Y	N	_____
High blood pressure	Y	N	_____
Mental illness	Y	N	_____
Diabetes	Y	N	_____
Thyroid trouble	Y	N	_____
Cancer	Y	N	_____
Other	Y	N	_____

Review of Symptoms

Extreme fatigue	Y	N
Marked weight changes	Y	N
Night sweats/hot flashes	Y	N
Headaches	Y	N
Dizziness or fainting	Y	N
Insomnia	Y	N
Depression	Y	N
Nausea or vomiting	Y	N
Rectal bleeding/black stools	Y	N
Constipation or diarrhea	Y	N
Increase frequency/urination	Y	N
Urine loss	Y	N
Blood in urine	Y	N