WOMEN LIVING WELL
OBSTETRICS & GYNECOLOGY

MEDICAL HISTORY

Today's Date: ______________ Name: _________________________________ Date of Birth: ____________

Please circle all that apply to YOUR health (previous or current conditions):

Alcoholism	Arthritis	Asthma	Blood Clot/DVT/PE	Cancer
Chlamydia	Depression	DES Exposure	Diabetes	Drug Addiction
Eating Disorder	Genital Warts	Gonorrhea	Headaches/Migraines	Heart Disease
Hepatitis	Herpes	High Blood Pressure	High Cholesterol	HIV
Kidney Disease	Lupus	Mental Health Disease	Osteoporosis	Seizures
Syphilis	Stroke	Thyroid Disease		

If you circled YES to any of the above, please explain, date of onset:

____

____

____

SURGICAL HISTORY

Surgery Name & Date:

____

____

____

CURRENT MEDICATIONS

Medication	Dose	When Taken

Allergies to medications, environment, or dyes:

____

FAMILY HISTORY

Please note Family Member & Maternal (M) or Paternal (P):

Breast Cancer: _________________

Diabetes: _________________

Heart Disease: _________________

Kidney Disease: _________________

Osteoporosis: _________________

Ovarian Cancer: _________________

Colon Cancer: __________________

Genetic Disorders: __________________

High Blood Pressure: __________________

Lung Cancer: __________________

Uterine Cancer: __________________

Thyroid Disease: __________________

Stroke/DVT/Clotting/Bleeding Disorder: ____

Other: ____

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MEDICAL HISTORY

Age when your period started?		What is your normal cycle length? (time between periods)	days
How long is your period?	days	Flow rate	Light Medium Heavy
When was your last menstrual period?		Age Menopause Began?	
What do you use for Birth Control?		Are you on Hormone Replacement Therapy?	
Do you have breakthrough bleeding between cycles?			

OB HISTORY

TOTAL # OF PREGNANCIES		TOTAL # OF MISCARRIAGES		TOTAL # OF ABORTIONS	

	DATE	SEX	METHOD OF DELIVERY	EARLY LABOR?	COMPLICATIONS	LOCATION OF DELIVERY
1						
2						
3						
4						
5						

Do you think of yourself as (circle): Heterosexual Homosexual Bisexual Other:___________________________

SOCIAL HISTORY

Do you smoke: Yes No If yes, amount: ___________________
Do you drink alcohol: Yes No If yes, amount: ___________________
Any drug use: Yes No If yes, type, & amount: ___________________

HEALTH MAINTENANCE

Did you receive Gardasil (HPV vaccination): Yes No

TEST/PROCEDURE	DATE	TEST/PROCEDURE	DATE
LAST DEXA		LAST MAMMOGRAM	
LAST COLONOSCOPY		LAST PAP SMEAR	