WOMEN LIVING WELL
OBSTETRICS & GYNECOLOGY

MEDICAL HISTORY

Today's Date: _____ Name: _____ Date of Birth: _____

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?			

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

Allergies to medications, environment, or dyes:

_____

Current Medications:

_____

_____

_____

Did you receive Gardasil (HPV vaccination): Yes No

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:

_____

_____

_____

WOMEN LIVING WELL
OBSTETRICS & GYNECOLOGY

SURGICAL HISTORY

Surgery Name & Date

_____

_____

_____

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: _____

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: _____

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						

HEALTH MAINTENANCE

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