All Women's Health

Medical History

This form is part of your permanent medical record. Please answer as completely as possible; all information is strictly confidential.

Name_____**Race**_____ **Weight**_____**Height**_____

Who came with you today?_____**Relationship**_____
Day telephone number where they can be reached_____

Have you been a patient here before?_____

Menstrual History

Are your periods normal and regular?_____

If not, explain_____

Bleeding is usually **LIGHT** **MEDIUM** **HEAVY**

How many days flow?_____

Cramping? **MILD** **MODERATE** **SEVERE**

Other symptoms with periods?_____

What age did you start your periods?_____

First Day of Last Normal Period_____ Normal?_____

Any bleeding or cramping since last period_____

Pregnancy History

Total number of pregnancies including this one_____
Number of live births_____Age of youngest child_____
Number of miscarriages_____Number of abortions_____
Living children_____ Number of C-sections_____
Any tubal pregnancies_____
Any bleeding problems with previous pregnancies?_____
_____
Symptoms during this pregnancy? Nausea ( ) Breasts tender ( ) Vomiting ( )
Fatigue ( ) Constipation ( ) Urinary frequency ( ) Vaginal Discharge ( )

Allergies to Drugs _____
_____

Medication or Drugs Presently Taking_____

Habits

Alcohol Use Never ( ) Occasionally ( ) Regularly ( )
Tobacco Use Yes_____ No_____

Past Medical History
(circle all that apply to you)

Cardiovascular Problems
Migraines
Rheumatic fever
Heart murmur
Stroke
Heart problem
Phlebitis (vein clots)
High blood pressure
Dizzy/fainting spells
Varicose veins
Anemia (low blood count)
Bleeding problems
Other blood problems

Mental Health Problems
Psychiatric problems
Physical and/or mental abuse
Chemical dependency

Pulmonary Problems
Asthma
Bronchitis
Tuberculosis
Emphysema

Renal Problems
Kidney problems/infections
Bladder problems/infections

Other Problems
Hepatitis/jaundice
Skeletal/back problems
Cancer
Thyroid disease

Female Problems
Infertility
Abnormal Pap smear
Endometriosis
Fibroids
Painful intercourse
Cancer

All Women's Health

Medical History

Previous Surgery (list)_____
_____

Family History Diabetes Cancer High Blood Pressure Heart Disease Stroke
Inherited diseases_____

Herpes (genital sores)
Tubal infections (PID)
Pelvic pain
Venereal diseases
Recurrent vaginal infections

I CERTIFY THAT WHAT I HAVE PROVIDED IS TRUE, CORRECT AND COMPLETE

Signature_____**Date**_____