PATIENT NAME: BIRTH DATE:

PATIENT HISTORY

GYNECOLOGIC HISTORY

FIRST DAY OF LAST MENSTRUAL PERIOD: / /	AGE PERIODS BEGAN:
LENGTH OF PERIODS (DAYS OF BLEEDING):	NUMBER OF DAYS BETWEEN PERIODS:
PRESENT METHOD OF BIRTH CONTROL:	HAVE YOU EVER HAD AN ABNORMAL PAP TEST?

OBSTETRIC HISTORY

NUMBER OF PREGNANCIES:					NUMBER OF MISCARRIAGES:	
NUMBER OF LIVE BIRTHS:					NUMBER OF ABORTIONS:	
NUMBER OF PREMATURE BIRTHS (<37 WEEKS):					NUMBER OF LIVING CHILDREN:	
	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY	PREGNANCY COMPLICATIONS
1.			☐ M ☐ F		☐ Vaginal ☐ C-Section	
2.			☐ M ☐ F		☐ Vaginal ☐ C-Section	
3.			☐ M ☐ F		☐ Vaginal ☐ C-Section	
4.			☐ M ☐ F		☐ Vaginal ☐ C-Section	

FAMILY HISTORY

MOTHER: ☐ LIVING ☐ DECEASED-CAUSE: AGE:	**FATHER**: ☐ LIVING ☐ DECEASED-CAUSE: AGE:

SIBLINGS: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

ILLNESS		WHICH RELATIVES	ILLNESS		WHICH RELATIVES
DIABETES	☐		TUBERCULOSIS	☐	
STROKE	☐		BIRTH DEFECTS	☐	
HEART DISEASE	☐		ALCOHOL OR DRUG PROBLEMS	☐	
BLOOD CLOTS IN LUNGS OR LEGS	☐		BREAST CANCER	☐	
HIGH BLOOD PRESSURE	☐		COLON CANCER	☐	
HIGH CHOLESTEROL	☐		OVARIAN CANCER	☐	
OSTEOPOROSIS	☐		UTERINE CANCER	☐	
HEPATITIS	☐		MENTAL ILLNESS/DEPRESSION	☐	
HIV/AIDS	☐		ALZHEIMER'S DISEASE	☐	
OTHER:	☐		OTHER:	☐	

SOCIAL HISTORY

	Yes	No		Yes	No
HAVE YOU EVER SMOKED?	☐	☐	DO YOU DRINK ALCOHOL?	☐	☐
DO YOU SMOKE NOW?	☐	☐	HOW MANY DRINKS PER DAY?		HOW MANY DRINKS PER WEEK?
HOW MANY PACKS PER DAY?			WHAT TYPE OF DRINK?		
DO YOU USE ILLEGAL DRUGS?	☐	☐			

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES		YES
ASTHMA/PNEUMONIA/LUNG DISEASE	☐	CHICKENPOX	☐
KIDNEY INFECTIONS/STONES	☐	CANCER	☐
TUBERCULOSIS	☐	REFLUX/HIATAL HERNIA/ULCERS	☐
FIBROIDS	☐	DEPRESSION/ANXIETY	☐
SEXUALLY TRANSMITTED DISEASE	☐	ANEMIA	☐
INFERTILITY	☐	BLOOD TRANSFUSIONS	☐
HIV/AIDS	☐	SEIZURES/CONVULSIONS/EPILEPSY	☐
HEART ATTACK/DISEASE	☐	BOWEL PROBLEMS	☐
DIABETES	☐	BROKEN BONES	☐
HIGH BLOOD PRESSURE	☐	HEPATITIS/YELLOW JAUNDICE/LIVER DISEASE	☐
STROKE	☐	THYROID DISEASE	☐
BLOOD CLOTS IN LUNGS OR LEGS	☐	HEADACHES	☐
EATING DISORDERS	☐	DES EXPOSURE	☐
AUTOIMMUNE DISEASE (LUPUS)	☐	BLEEDING DISORDERS	☐

OTHER:

LIST SURGERY: