

Patient History Name: Date of Birth:

Personal History of Past Illness

Major Illness	Yes (Date)	Major Illness	Yes (Date)
Anemia		Glaucoma	
Arthritis / Joint Pain		Headaches (chronic only)	
Asthma		Heart Disease	
Back Problems		Hepatitis/Yellow Jaundice/Liver Disease	
Blood Clot in Lungs or Legs		High Blood Pressure	
Blood Transfusions		High Cholesterol	
Bowel Problems		HIV/Aids	
Broken Bones		Kidney Infection/Kidney Stones	
Cancer		Pneumonia/Lung Disease	
Cataracts		Reflux/Hiatal Hernia/Ulcer	
Chickenpox		Rheumatic Fever	
Collagen Vascular Disease (Lupus)		Seizures/Convulsions/Epilepsy	
Depression or Anxiety (circle)		Sexually Transmitted Disease	
Diabetes		Stroke	
Eating Disorders		Thyroid Disease	
Gallbladder Disease		Tuberculosis	
Other			

GYN History

Abnormal Hair Growth		Infertility		
Abnormal Bleeding		Ovarian Cyst		
Abnormal Pap Smear		Osteoporosis		
Breast Problems		Sexual Problems		
Cyst of Vulva		Sexually Transmitted Disease		
DES Exposure		Uterine Abnormality		
Endometriosis		Urinary Leakage		
Fibroid Uterus		Vaginal/Vulvar Infection		

Surgeries

Surgery	Yes	No	Date / Comments
Abdominal Surgery			
C-Section Delivery			
Dilation & Curettage (D & C)			
Hysterectomy			
Hysteroscopy (out patient)			
Laparoscopy (out patient)			
Vaginal Surgery			
Bartholin Glands Surgery			
Other (please specify)			

Social History

Preferred Name:	PCP:	Occupation:
Number of People in Household:	Single Married Widowed Divorced Separated Living w/Partner	
Education (last grade completed):	Name of significant other:	
Children's Names:		
Seat Belt Use: Always Frequently Occasionally Never		
How many days per week do you exercise?	How many packs of cigarettes per day do you smoke?	
How many times per week do you drink alcohol?		
Do you use any of the following? Cocaine Narcotics Marijuana Hallucinogens		

Family History – Please check all that apply

Illness	Mother	Father	Sibling	Child	Maternal GMother	Maternal GFather	Paternal GMother	Paternal GFather	Other (who)
Breast Cancer									
Colon Cancer									
Ovarian Cancer									
Alzheimer's Disease									
Birth Defects									
Blood Clots in lungs or legs									
Diabetes									
Drinking or Drug Problem									
Endometriosis									
Fibroids									
Heart Disease									
Hepatitis									
High Blood Pressure									
High Cholesterol									
HIV/AIDS									
Mental Illness/Depression									
Osteoporosis									
Stroke									
Tuberculosis									
Other									

Obstetric History

_____ # Total Pregnancies	_____ # Full Term	_____ #Premature	_____ # Elective Abortions
_____ # Miscarriages	_____ # Ectopic	_____ # Multiples	_____ # Living _____ #Adopted

Pregnancy Details	#1	#2	#3	#4	#5	#6+
Pregnancy Outcome F = Full term, P = Premature, M = Miscarriage						
Delivery Date						
Weeks at Delivery						
Length of Labor (hrs)						
Epidural/Anesthesia						
Delivery Type V = Vaginal, C = C-Section						
Did you have Pre-term Labor?						
Delivery Location?						
Who delivered your baby?						
Baby weight?						
Baby Sex?						
Baby Name?						

Complications of Pregnancy	Please check all that apply					
Gestational Diabetes						
Macrosomia						
Multiple Gestation						
Post Dates						
Postpartum hemorrhage						
Pre-eclampsia						
Preterm Delivery						
Other Complication						