Patient Name: _____ Date of Birth: _____

Patient History Form

Please check all that <u>YOU</u> have had in the past or have currently.

___ Abnormal Mammogram
___ Abnormal Pap
___ Acne
___ Adrenal Gland Disease
___ Alzheimer's Disease
___ Anemia
___ Anxiety
___ Appendicitis
___ Asthma
___ Atrial Fibrillation
___ Attention Deficit Disorder
___ Bacterial Vaginitis
___ Bartholin's Cyst
___ Bipolar Disorder
___ Bladder Fistula
___ Brain Injury
___ Brain Tumor
___ Breast Cancer
___ Breast Fibroadenosis
___ Breast Mass
___ Breast Pain/Mastodynia
___ Breech Presentation
___ Bronchitis, Chronic
___ Cardiomyopathy
___ Cervical Cancer
___ Cervical Dysplasia
___ Cervical Incompetence
___ Cesarean Delivery
___ Chest Pain
___ Chlamydia
___ Cholecystitis
___ Chronic Back Pain
___ Chronic Hypertension
___ Cleft Lip
___ Cleft Palate
___ Clotting Disorders
___ Coarctation of Aorta
___ Colon Cancer
___ Colon Polyps
___ Congenital Anomaly of Heart
___ Congestive Heart Failure
___ Crohn's Disease
___ Depression
___ Diabetes, Type 1
___ Diabetes, Type 2
___ Diverticulitis of Colon
___ Ectopic Pregnancy
___ Eczema
___ Endometrial Cancer
___ Epilepsy/Seizures
___ Excessive Hair Growth
___ Failure to Progress in Labor
___ Fetal Chromosomal Abnormality
___ Fetal Size- Abnormally Large
___ Fibroids, uterine
___ Fibromyalgia
___ Fragile X Syndrome
___ Gastric Reflux
___ Genital Herpes
___ Gestational Diabetes
___ Gestational Hypertension
___ Gonorrhea
___ Grave's Disease
___ Group B Strep
___ Hashimoto's Disease
___ Heart Murmur
___ Heart Palpitations
___ Hematuria (Blood in Urine)
___ High Cholesterol
___ Hip Fracture
___ HIV/AIDS
___ Human Papilloma Virus (HPV)
___ Hydatidform Mole
___ Hyperthyroidism
___ Hypothyroidism, Acquired
___ Hypothyroidism, Congenital
___ Infertility
___ Irritable Bowel Syndrome
___ Kidney Cancer
___ Kidney Failure
___ Kidney Infections, Chronic
___ Kidney Stones
___ Leukemia
___ Liver Disease
___ Lung Cancer
___ Lyme Disease
___ Lymphoma
___ Marfan Syndrome
___ Mastitis, Postpartum
___ Migraines
___ Multiple Sclerosis
___ Obsessive-Compulsive Disease
___ Osteoarthrosis
___ Osteoporosis
___ Ovarian Cancer
___ Pancreatitis
___ Panic Disorder
___ Parkinson's Disease
___ PCOS
___ Pelvic Fracture
___ Pelvic Prolapse
___ Pituitary Tumor
___ Placenta Abruption
___ Placenta Previa
___ Pneumonia, Bacterial
___ Pneumonia, Viral
___ Polydactyly
___ Postpartum Depression
___ Preeclampsia
___ Premature Delivery
___ Psoriasis
___ PTSD
___ Pulmonary Embolism
___ Rheumatoid Arthritis
___ Sarcoidosis
___ Schizophrenia
___ Scleroderma
___ Scoliosis
___ Shortness of Breath
___ Sickle Cell Disease
___ Sickle Cell Trait
___ Sinusitis, Chronic
___ Skin Cancer
___ Slipped Disk
___ Spina Bifida
___ Stroke
___ Suicide Attempt
___ Syncope
___ Syphilis
___ Thrombocytopenia
___ Thrombophilia
___ Thyroid Cancer
___ Thyroid Goiter
___ Tuberculosis
___ Twin Pregnancy
___ Ulcerative Colitis
___ UTI's, Recurrent
___ Vitiligo (Loss of Skin Pigment)
___ Von Willebrand's Disease
___ Yeast Infections

Other medical conditions not listed:

_____

_____

_____

_____

_____

Please list any surgeries you have had:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List any medications you are currently taking:

Medication Name/Dose	Medication Name/Dose
1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10._____

List any drug allergies/allergies you may have:

___ No Known Drug Allergies	___ No Known Allergies
_____	_____
_____	_____
_____	_____

Family Medical History

Does anyone in your family have/previously had:

	Who (Maternal/Paternal)	Type
Asthma	_____	_____
Cancer	_____	_____
	_____	_____
	_____	_____
	_____	_____
Diabetes	_____	_____
Heart Disease/Attack	_____	_____
Hypertension	_____	_____
Stroke	_____	_____
Birth Defects	_____	_____
High Cholesterol	_____	_____
Osteoporosis	_____	_____

Reproductive History

What was the age of your first period? _____ How many days are in between cycles? _____

How many days do you bleed? _____ Last Menstrual Period Date: _____

Are you menopausal? Yes No What age did it start? _____

Current Method of Birth Control: _____

Pregnancy History (Please list all miscarriages, abortions, ectopic pregnancies, etc.)

Date	Weight	Gender	Type	Anesthesia	Hospital	Complications	Living?

Social History

Marital Status: _____

____ Never Smoker ____ Former Smoker ____Current every day smoker

Do you use any street drugs or alcohol? Yes No Type: _____

Education Level: _____

Occupation: _____