

ASSOCIATES IN WOMEN'S CARE, PC
Patient Medical History

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Marital Status: _____ Spouse's Name: _____

Referred By: _____

Have you been referred here for a particular problem? _____

GYN History

Are your periods regular: Yes No
 Days between periods (start to start) _____
 Days of flow: _____

Do you have:

Pain with periods?	Yes	No
Pain with sex?	Yes	No
Excess bleeding with periods?	Yes	No
Bleeding after sex?	Yes	No
Have you gone through menopause?	Yes	No
If yes, when? _____		
Are you taking hormones?	Yes	No

Have you ever had an abnormal pap smear?	Yes	No
Have you ever had a mammogram?	Yes	No
Do you do self breast exams? Sometimes _____	Yes	No
Have you had any breast problems?	Yes	No

Do you have a sexual partner? Yes No
 What form of contraception are you using?
 Pill _____ IUD _____ Diaphragm _____ Condoms _____ Sterilization _____ Other: _____

Have you ever had a sexually transmitted disease?	Yes	No
Have you ever had a pelvic infection?	Yes	No

Have you ever been vaccinated for/or had German Measles?	Yes	No
Have you ever been vaccinated for HPV(Gardasil)?	Yes	No

OB History

List all pregnancies in order (including miscarriages & abortions)

Date	Sex	Weight	Type of Delivery	Complications

General Medical History

List any medications you are taking: _____

Drug Allergies: _____ Yes No
If yes what? _____

List any surgeries you have had: _____

Any other hospitalizations? _____

Date of last Tetanus shot? _____

Have You Ever Had:

Seizures, stroke, migraine headaches, or other neurologic disorders?	Yes	No
Asthma, TB or other lung disorder?	Yes	No
High blood pressure?	Yes	No
Heart murmur?	Yes	No
Heart disease?	Yes	No
Blood clot in leg or lungs?	Yes	No
Vascular disease?	Yes	No
Intestinal, gallbladder or stomach problems?	Yes	No
Hepatitis or liver disease?	Yes	No
Diabetes?	Yes	No
Thyroid disease?	Yes	No
Frequent bladder or urinary tract infection?	Yes	No
Kidney disease?	Yes	No
Skin diseases?	Yes	No
Bleeding disorder?	Yes	No
Blood transfusion?	Yes	No
Positive HIV test?	Yes	No
Hayfever or allergies?	Yes	No
Breast problems?	Yes	No
Any form of cancer?	Yes	No

Family History:

Has anyone in your family had:			
Cancer?	Yes	No	Who _____
Heart disease?	Yes	No	Who _____
Diabetes?	Yes	No	Who _____
Stroke?	Yes	No	Who _____
High blood pressure?	Yes	No	Who _____
Osteoporosis?	Yes	No	Who _____

Personal History:

Do you smoke?	Yes	No	How much? _____
Do you drink alcohol?	Yes	No	How much? _____
Do you exercise regularly?	Yes	No	How often? _____
Do you consume dairy products or take calcium?	Yes	No	
Do you use sunscreen?	Yes	No	

Any special concerns or comments? _____
