HEALTH HISTORY

Name ______________________________ Date of Birth ____________ Age _____ Today's Date ____________

Reason for visit today: ____

Menstrual History: Last Menstrual Period ____________

Age of first menses ______ Regular cycles every ______ days. Irregular Cycles ________
Average days of flow ______ Heavy ______ Painful ______

Premenstrual Symptoms: ____________________ Menopausal Symptoms: ____________________
Hormone Replacement Therapy: ____________________ Duration of Hormone Use: ____________________

When was your last Mammogram? ____________ When was your last Pap? ____________ Normal? ________

Pregnancy History:

# of pregnancies ______ # of live births ______ # of still births ______ # of miscarriages ______ # of abortions ______
Do you use any method of contraception? ______ Yes ______ No
If yes, currently using: ____________________ Have previously used: ____________________

Any history of infertility? __________

Are you sexually active? ________ Does sex cause pain or bleeding? ______ Yes ______ No
Do you have any history of sexual abuse? ____________ Any history of domestic violence? ____________

Have you ever had trouble with: ROS _____ M.D. _____

______ Blood pressure ____ too high ____ too low
______ Heart disease ____ high cholesterol or triglycerides
______ Asthma
______ Kidney
______ Bladder ____ Infections ____ Incontinence
______ Liver ____ Hepatitis A ____ Hepatitis B ____ Hepatitis C
______ Stomach or Intestines
______ Gallbladder
______ Diabetes ____ Insulin
______ Cancer
______ Neurologic Problems
______ Unusual Weight Loss/Gain

______ Pelvic infections ____ Chlamydia ____ Gonorrhea ____
______ Pelvic pain ____ Endometriosis
______ Ovarian cysts
______ Herpes
______ Fibroids
______ Breast ____ prior biopsy
______ Blood clots
______ Transfusions
______ Anemia
______ Thyroid disease
______ Depression/Anxiety ____ present ____ previous
______ Other ____________________

Previous Surgeries: ____________ ____________ ____________
____________ ____________ ____________

Do you have any allergies to medications? ____________________________
Do you take any medications? ____________ ____________ ____________
____________ ____________ ____________

Do you smoke? ______ Do you use recreational drugs? ______ Do you drink alcohol? ____ Intake __________

Does anyone in your family have a history of:

______ Breast Cancer ______ Colon Cancer ______ Ovarian Cancer ______ Osteoporosis
______ Uterine Cancer ______ Heart Disease ______ Diabetes ______ Birth defects or Genetic Disorder