PATIENT'S PERSONAL MEDICAL HISTORY **Date: _____**

Name _____ Age _____

Last Name First Name Middle Name

Ethnicity _____ Height _____Weight _____ Will You Accept Blood Y☐ N☐

PERSONAL HISTORY

GYNECOLOGICAL HISTORY			
DATE OF LAST PERIOD:			**DURATION OF MENSES:**
AGE OF ONSET OF MENSES:			**DAYS BETWEEN MENSES:**
	Y	**N**	
Have you ever missed a period except when pregnant?	☐	☐	
Has your period ever lasted more than 8 days or less than 2 days?	☐	☐	
Did you ever pass large clots during your period?	☐	☐	
CONTRACEPTIVE HISTORY:	**Y**	**N**	
Have you ever taken birth control pills?	☐	☐	
Are you presently taking birth control pills? If yes, which one?	☐	☐	
If no, what form of contraception do you use?	☐	☐	

Do you have or have you ever had any of the following conditions?

	Y	N	If yes, explain.		Y	N	If yes, explain.
Diabetes	☐	☐		Illicit Drug use	☐	☐	
High Blood Pressure	☐	☐		Rh Sensitization	☐	☐	
Heart disease	☐	☐		Lung/Asthma/TB	☐	☐	
Autoimmune disease	☐	☐		Seasonal Allergies	☐	☐	
Kidney disease/UTI	☐	☐		Drug/Latex Allergies	☐	☐	
Epilepsy/Neurological	☐	☐		Breast disease	☐	☐	
Psychiatric Problems	☐	☐		Anesthetic Problems	☐	☐	
Depression	☐	☐		Abnormal paps	☐	☐	
Hepatitis/Liver disease	☐	☐		Uterine Abnormalities	☐	☐	
Clotting/Phlebitis	☐	☐		Infertility	☐	☐	
Thyroid problems	☐	☐		Chicken Pox	☐	☐	
Trauma/Violence	☐	☐		Exposure to TB	☐	☐	
Blood Transfusion	☐	☐		Exposure to Herpes	☐	☐	
Tobacco use	☐	☐		Rash or viral illnesses	☐	☐	
Alcohol use	☐	☐		History of STDs	☐	☐	
Other	☐	☐		Other	☐	☐	

List all prescription and over-the-counter medications you are currently taking?

MEDICATIONS	DOSAGE		MEDICATION	DOSAGE

Main reason for your visit

Name: _____

GENETIC HISTORY (For Pregnant Patients Only)

Do you, the baby's father or anyone on either side of the family have or ever had any of the following?

	Y	N	If yes, explain.
Age over 35 years at time of delivery	☐	☐	
Thalassemia (Italian, Greek, Mediterranean or Asian)	☐	☐	
Spina Bifida, Meningomyelocele or Anencephaly	☐	☐	
Congenital Heart Defect	☐	☐	
Down Syndrome	☐	☐	
Tay-Sachs (Jewish, Cajun, or French Canadian)	☐	☐	
Canavan Disease	☐	☐	
Sickle Cell Disease or trait (African)	☐	☐	
Hemophilia or other blood disorders	☐	☐	
Muscular Dystrophy	☐	☐	
Cystic Fibrosis	☐	☐	
Huntington's Chorea	☐	☐	
Mental Retardation/ Autism	☐	☐	
Other inherited genetic or chromosomal disorders	☐	☐	
Maternal Metabolic Disorder (i.e. Type I Diabetes, PKU)	☐	☐	
Other birth defects from baby's father	☐	☐	
Recurrent pregnancy loss or stillbirth	☐	☐	
Exposure to medication (including supplements, vitamins, herbs, illicit drugs, alcohol) since last period.	☐	☐	
Exposure to chemicals or radiation (work hazards)	☐	☐	

PERSONAL HISTORY (Continued)

ALLERGIES: List the names of any drugs to which you are allergic and state the reaction you have had:

_____

_____

OPERATIONS: List the operations (major or minor) you have had as well as the hospital location and date:

_____

_____

ILLNESSES OR DISEASES: List the names of any illnesses or diseases you have now or had in the past:

_____

_____

INJURIES OR ACCIDENTS: List any serious injuries or accidents you have had and the date:

_____

_____

PERSONAL AND FAMILY CANCER HISTORY

Do you or any member of your family have or ever had any of the following Cancer

	Y	N	If yes, explain.		Y	N	If yes, explain.
Breast	☐	☐		Ovaries	☐	☐	
Cervix	☐	☐		Colon	☐	☐	
Uterus	☐	☐		Other	☐	☐	

PREFERRED PHARMACY (Name, location, Phone): _____

Name: _____

PERSONAL HABITS & PRACTICES:	**Y**	**N**	**If yes,**	**If yes,**
Do you smoke cigarettes regularly?	☐	☐	Packs/day?	How long?
Do you regularly drink alcohol?	☐	☐	Ounces/day? Beers/day?	How long? How long?
Do you use any illegal drugs?	☐	☐	What?	Last Use?
Do you drink over 4 cups of coffee per day?	☐	☐	Cups/day?	How long?
Do you have a Pap smear yearly or regularly?	☐	☐	Date of last pap:	☐ Normal ☐ Abnormal
Have you ever had a mammogram?	☐	☐	Date of last one:	☐ Normal ☐ Abnormal
Have you ever had your cholesterol checked?	☐	☐	Date of last test:	☐ Normal ☐ Abnormal
Do you perform monthly self-breast exams regularly?	☐	☐		

OBSTETRICAL HISTORY (including miscarriages and elective abortions)**:**							
Date (Mo/Year)	**Full Term**(FT) **Preterm** (PT) **Miscarriage** (Sab) **Abortion** (Tab)	**Hours in Labor**	**Birth Weight** (Lbs/Ozs)	**Sex** (M/F)	**Vaginal Birth** (V) **or C-Section**(CS)	**Anesthesia** (if any)	**Complications** (Mother or Baby)