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 Clots in lungs or legs		High Blood Pressure	
Blood Transfusions		High Cholesterol	
Bowel Problems		HIV/Aids	
Broken bones		Kidney Infections/Kidney Stones	
Cancer		Pneumonia/Lung Disease	
Cataracts		Reflux/Hiatal Hernia/Ulcers	
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

Problem	Yes	No	Problem	Yes	No
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		

GYN 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			

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		
Occupational Risks: None Biohazard Chemical Physical Labor		
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		
Have you ever been or are you currently being physically, verbally or sexually abused?		

Family History- Please check those that apply

Illness	Mother	Father	Sibling	Child	Maternal Grandparent	Paternal Grandparent	Other
Breast Cancer							
Colon Cancer							
Ovarian Cancer							
Alzheimer's Disease							
Birth Defects							
Blood Clots in lungs or legs							
Diabetes							
Drinking or Drug problems							
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 Abortion	
# Miscarriage		#Ectopic		#Multiples		#Living	

Pregnancy #	**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	**Please check any that apply**					
Gestational Diabetes						
Macrosomia						
Multiple Gestation						
Post Dates						
Post partum hemorrhage						
Pre-eclampsia						
Preterm Delivery						
Other Complications						