MEDICAL INFORMATION

NAME:_____ Date: _____

Reason for today's visit: _____

_____

Please list all medications & dosages you are currently taking, including vitamins, herbs and over-the-counter medications. An allergic reaction includes rash, hives, swelling of face or difficulty breathing.

_____

_____

_____

Please list all previous and present medical illnesses:

❒Asthma ❒High blood pressure ❒High cholesterol ❒Thyroid disease ❒Mitral valve prolapse ❒Stroke
❒Heart disease ❒Sugar diabetes ❒Hepatitis ❒Epilepsy ❒Blood clots in legs or lung ❒Psychiatric problem
❒ Cancer - Type _____
❒ Others _____

Gynecologic history

❒ Abnormal pap smear Grade _____ Type of treatment _____
❒ Breast mass or biopsy ❒ Endometriosis ❒ Uterine fibroids
❒ Herpes infection ❒ Genital warts ❒HPV ❒ Chlamydia ❒ Gonorrhea ❒ Syphilis
❒ Loose urine on coughing or sneezing ❒Have sensation that organs are falling out of vagina
❒ Pain with intercourse ❒ Low sex drive ❒ Unable to achieve orgasm ❒ Bleeding after intercourse
❒ Others sexual problems: _____
❒ Are you involved in a same sex relationship? ❒Y ❒N - You can advise me personally if you do not feel comfortable answering this question
Other female related problems _____
When was your last pap smear ? _____
When was your last mammogram? _____
When was your last bone density test? _____
When was your last colonoscopy? _____

Menstrual history:

When was your last normal period?_____ Age of your first menstrual period _____
What is the interval between your periods _____ How long does your period last ?_____days
Do you have vaginal bleeding between period? ❒ Yes ❒ No
Do you have cramps with your periods? ❒ Yes ❒ No Please rate the severity of your menstrual cramps on the scale from 1 (Mild) to 10 (Severe) _____/10
Are your menstrual flow? ❒ Normal ❒ Moderate ❒ Heavy
Do you pass blod clots during your cycles? ❒ Yes ❒ No
How many pads or tampons do you change on the heaviest day? _____
Are you menopausal? ❒ Yes ❒ No If so, what year? _____

Chart number:_____

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Contraception history

What kind of contraception are you using? ❒ Birth control pills Name of pills_____

❒ None ❒ Abstinence ❒ Birth control patch ❒ Depo-Provera ❒ Condom ❒ Foam

❒ Diaphragm ❒ Withdrawal ❒ Rhythm ❒ Tubal ligation ❒Essure ❒ Vasectomy

❒ IUD / Type of IUD and year of insertion _____

Pregnancy history:

How many times have you been pregnant? _____ Number of miscarriages_____

Number of abortions_____ Number of living children_____

Please list each pregnancy below

No.	Date	Total weeks pregnant	Sex of baby	Birth weight	Hours in labor	Type of anesthesia	Type of deliveries	Complications
1								
2								
3								
4								
5								
6								

Previous surgeries (Including C-sections, tubal ligation, tonsillectomy and cosmetic surgeries)

1._____Year_____

2._____Year_____

3._____Year_____

4._____Year_____

5._____ Year_____

Family history: First degree relative (Father, mother, brother, sister)

	Relationship		**Relationship**
❒ Diabetes	_____	❒ Breast cancer	_____
❒ Hypertension	_____	❒ Colon cancer	_____
❒ Heart disease	_____	❒ Ovarian cancer	_____
❒ Blood clots	_____	❒ Stroke	_____
❒ Others	_____		

Mother ❒Living ❒Deceased /Age and cause of death _____

Father ❒Living ❒Deceased /Age and cause of death _____

Sisters ❒Living ❒Deceased /Age and cause of death _____

Brothers ❒Living ❒Deceased /Age and cause of death _____

Do you smoke ? ❒Yes ❒ No # of cigarettes per day _____ for_____years

Do you drink alcohol excessively ? ❒ Yes ❒ No

Do you use recreational drugs? ❒ Yes ❒ No Describe: _____

Name:_____

Chart number:_____