Patient History

Name______________________________________D.O.B_____/_____/______Date_____/_____/_____

Allergies/Reactions to Medication____

____

Medications____

____

Surgeries/ Biopsies (year)____

____

YOUR medical history

- ○ High blood pressure
- ○ Diabetes
- ○ Heart disease
- ○ Stroke
- ○ Bleeding disorder, abnormal blood clots
- ○ Endometriosis
- ○ Asthma
- ○ Seizures
- ○ Lupus/ other joint disease
- ○ Depression
- ○ Anxiety
- ○ Bipolar disorder
- ○ Anorexia/ Bulimia
- ○ Irritable bowel syndrome
- ○ Crohn's disease/ Ulcerative colitis
- ○ Breast Cancer
- ○ Cancer of the uterus, cervix/ovary
- ○ Colon Cancer
- ○ Thyroid disease
- ○ Other____________________________

FAMILY medical history

Father/ Mother	Brother/Sister	Grandparents	Uncle/Aunt
Father/ Mother	Brother/Sister	Grandparents	Uncle/Aunt
Father/ Mother	Brother/Sister	Grandparents	Uncle/Aunt
Father/ Mother	Brother/Sister	Grandparents	Uncle/Aunt
Father/ Mother	Brother/Sister	Grandparents	Uncle/Aunt
Father/ Mother	Brother/Sister	Grandparents	Uncle/Aunt
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Father/ Mother	Brother/Sister	Grandparents	Uncle/Aunt
Father/ Mother	Brother/Sister	Grandparents	Uncle/Aunt
Father/ Mother	Brother/Sister	Grandparents	Uncle/Aunt

Gynecologic History

Age of first period:____________ Age of final period:______________ Frequency of periods (every)______(day)
Duration of flow: ____________(days) Last Pap:____/____/_____ Abnormal Paps:____/____/____

Treatment for abnormal Pap(s):

(year):	Cryotherapy	LEEP	Cone Biopsy	Laser Ablation

Treatment for the following:

(year):	Gonorrhea	Chlamydia	PID	Herpes	Warts/HPV

Occupation:___________________Marital Status:____________Birth Control:______________Exercise Routine:________________
Tobacco: Y / N (years)________ Alcohol: Y / N (years)_________ Drugs: Y / N (years)_________

Pharmacy Information

Pharmacy____

Location____Zip____________________

Contact (   )____

FOR OFFICE USE ONLY

Obstetrical History

G__________P__________A__________

DELIVERY TYPE	YEAR	WEIGHT	GENDER	COMPLICATIONS