

MENSTRUAL History: Age periods began _____ First day of last period ____/____/____
Periods every _____ days. Was this a normal period? Y / N
If no, explain _____

OBSTETRICAL History: Number of total pregnancies _____ Live Births _____
Miscarriages _____ Abortions _____ Premature Births _____
Age of children _____ Comments: _____

CONTRACEPTIVE History: Current Method _____
List all methods (used formerly & length of use) _____

ALLERGY History: Please list all medication allergies: _____

MEDICAL History:

Anemia	Y/N _____	Seizures	Y/N _____	Stroke	Y/N _____
Migraine Headache	Y/N _____	Diabetes	Y/N _____	Arthritis	Y/N _____
High Blood Pressure	Y/N _____	Heart Failure	Y/N _____	Alcohol	Y/N _____
Heart Attack	Y/N _____	Rheumatic Fever	Y/N _____	Asthma	Y/N _____
High Cholesterol	Y/N _____	Stomach Ulcers	Y/N _____	Colitis/IB	Y/N _____
Lung Disease	Y/N _____	Liver Disease	Y/N _____	Cancer	Y/N _____
Hepatitis A,B or C	Y/N _____	Urine Incontinence	Y/N _____	Phlebitis	Y/N _____
Bladder Infection	Y/N _____	Thyroid Disease	Y/N _____	Lupus	Y/N _____
Kidney Disease	Y/N _____	Sickle Cell	Y/N _____	Anxiety	Y/N _____
Blood Transfusions	Y/N _____	Stroke	Y/N _____	Depression	Y/N _____
				Other mental conditions	Y/N _____

Do you smoke? Y / N _____ If yes, how many packs a day? _____

GYNECOLOGICAL History:

DES Exposure	Y/N _____	Abnormal Pap	Y/N _____	Chlamydia	Y/N _____
Recurrent Vaginitis	Y/N _____	Pelvic Infections (PID)	Y/N _____	Gonorrhea	Y/N _____
Endometriosis	Y/N _____	Chronic Pelvic Pain	Y/N _____	PMS	Y/N _____
Pain w/Intercourse	Y/N _____	Fibroid Tumors	Y/N _____	Herpes	Y/N _____
Condyloma (warts)	Y/N _____	Ovarian Cysts	Y/N _____	AIDS/HIV	Y/N _____
Urinary Incontinence	Y/N _____	Pelvic Pressure	Y/N _____	Infertility	Y/N _____
Recurrent Miscarriage	Y/N _____	Cervical Cancer	Y/N _____	Breast Pain	Y/N _____

SURGICAL History: Please list all surgical procedures and their year _____

FAMILY History: Any family history of heart disease, cancer, mental problems, diabetes, breast or gynecological problems? If yes, List who and what problems: _____

MEDICATION History: Please list ALL medications with strength and dosage: _____