PATIENT HISTORY

Date: _____ Chart #:_____ Reason For Visit:_____
First Name: _____ Last Name: _____
Allergies: _____MRSA Yes or No
Symptoms *(Please list any symptoms that you would like to discuss with your doctor today*):_____
_____
_____

GYN HISTORY *(Fill in the blank or check the appropriate answer)*

Age onset of menses:_____ **Periods regular?** Yes ❑ No ❑ **Periods painful?** Yes ❑ No ❑

Abnormal Pap Smears? Yes ❑ No ❑ **Date of last pap smear:**_____ **Birth Control Method:**_____

History of Chlamydia? Yes ❑ No ❑ **Gonorrhea?** Yes ❑ No ❑ **Pelvic Inflammatory Disease?** Yes ❑ No ❑

Sexual History: Sexually Active (past or present)? Yes ❑ No ❑ **Abuse:** Yes ❑ No ❑

OBSTETRIC HISTORY *(List pregnancies in order)*

	Year	Type of Delivery	M or F	Weight	Complications
1.					
2.					
3.					
4.					
5.					

CURRENT MEDICAL PROBLEMS (Describe)

1.		4.	
2.		5.	
3.		6.	

HOSPITALIZATIONS & OUTPATIENT SURGERIES

	Year	Reason	Doctor	Comments
1.				
2.				
3.				

PERSONAL/FAMILY/ & SOCIAL HISTORY

(Put "self", "father", or "mother", etc. as appropriate. (Describe as needed in space provided labeled "other")

Heart Disease? Yes ❑ No ❑ **Who?**_____ **Stroke?** Yes ❑ No ❑ **Who?**_____
Diabetes? Yes ❑ No ❑ **Who?**_____ **Hypertension?** Yes ❑ No ❑ **Who?** _____
Osteoporosis? Yes ❑ No ❑ **Who?**_____ **Blood Clots?** Yes ❑ No ❑ **Who?** _____
Cancer? Yes ❑ No ❑ **Who?**_____ **Other:**_____
Religion:_____ **Marital Status: S ❑ M ❑ D ❑ W ❑**
Tobacco? Yes ❑ No ❑ **# Cigarettes/day: _____ Alcohol?** Yes ❑ No ❑ **# Drinks/week:**_____
Drugs? Yes ❑ No ❑ **Type: _____**

Patient Signature:_____

Parent or guardian if patient is under 18