

PATIENT HISTORY

PAST MEDICAL HISTORY: _____
 PRESENT SOURCE OF HEALTHCARE: _____ HOW IS YOUR HEALTH NOW? _____
 LAST PHYSICAL EXAM? _____ LAST PELVIC EXAM? _____ LAST PAP SMEAR? _____
 IS THERE FAMILY HISTORY OF: CANCER _____ DIABETES _____ HEART DISEASE _____ HIGH BLOOD PRESSURE _____
 STROKE _____ BLOOD CLOTS _____ SEVERE ALLERGIES _____ OTHER _____

HAVE YOU HAD ANY TROUBLE WITH:

.. High Blood Pressure	.. Sexually-Transmitted Disease	.. Dimness	.. Sickle Cell Trait
.. Heart Disease	.. Cervix Problems (or Treatments)	.. Emotional Problems	.. Rh Factor
.. Mitral Valve Prolapse	.. Warts	.. Ovarian Problems	.. Tension
.. Thyroid	.. Acne	.. Uterine Problems	.. Depression
.. Diabetes	.. Kidney, Bladder	.. Anesthesia Problems	.. ALLERGIES (list below)
.. Blood Clots	.. Cancer	.. Hirsutism (Excess Hair)	.. _____
.. Lung Problems	.. Headaches, Migraines	.. Liver Disease	.. _____
.. Breast Problems	.. Varicose Veins	.. Eyes	.. _____
.. Pelvic Infection	.. Anemia	.. Diabetes	
.. Vaginal Discharge	.. Transfusions	.. Seizures	

DO YOU WEAR GLASSES? _____ CONTACT LENSES _____ DO YOU BRUISE OR BLEED EASILY? _____
 DO YOU SMOKE? _____ HOW MUCH? _____ FOR HOW LONG? _____ DO YOU WISH TO DISCUSS QUITTING? _____

LIST ALL MEDICATIONS (WITH DOSAGE) THAT YOU ROUTINELY TAKE, OR ARE TAKING NOW (INCLUDING ASPIRIN, MOTRIN, ETC.).

LIST ALL MAJOR (OR MINOR) **SURGERY, OR ILLNESSES** - INCLUDE ANY PROCEDURES ON THE CERVIX ("CRYO, FREEZING, CAUTERY, LASER, LEEP")

Date?	Hospital?	City?	State?	Problems and/or Diagnosis?	Surgery and/or Treatment?

PAST PREGNANCY HISTORY: AGE AT FIRST PREGNANCY: _____ NUMBER OF LIVING CHILDREN: _____

Date of Pregnancy?	Vaginal Delivery?	Cesarean Section?	Live Birth?	Miscarriage	Elective-Abortion?	Number Weeks?	Hospital, or Clinic?	List ANY complications in the pregnancy?

MENSTRUAL HISTORY: FIRST DAY OF LAST MENSTRUAL PERIOD ("L. M. P."): ____ / ____ / ____.
 AGE AT YOUR FIRST PERIOD? _____ NUMBER DAYS OF FLOW? _____ IS YOUR FLOW? .. LIGHT .. MEDIUM .. HEAVY
 PRE-MENSTRUAL TENSION? _____ CRAMPS? _____ IS YOUR CYCLE? .. REGULAR .. IRREGULAR

CONTRACEPTIVE HISTORY:
 WHAT METHOD(S) OF CONTRACEPTION HAVE YOU USED? _____
 WHEN? _____ PREVIOUS PILLS USED _____ TOTAL TIME ON PILLS? _____
 PROBLEMS OR COMPLICATIONS WITH PREVIOUS BIRTH CONTROL METHODS? _____

 WHAT METHOD DO YOU WANT TO USE NOW? _____

PRACTITIONER'S COMMENTS:

