PATIENT HISTORY FORM



Please help us by giving some information	on about your nearth.	Please complete both side	es and nii in an spaces. Piease pini			
Today's Date:	_					
Patient Name:		Date of Birth:	Age:			
Primary Care Doctor:						
Other physicians treating you:						
Current medications:						
Medication allergies:						
Other allergies:		I	atex allergy: O Yes O No			
Reason for your visit:						
PAST GYN HISTORY						
Last menstrual period:		Age when periods be	gan:			
Length of periods:		How many days between periods?				
Do you do self breast exams? O Yes O N	lo					
Last Pap Smear:		Result:				
Last Mammogram:		Result:				
Last Bone Density Test:		Result:				
Last Colonoscopy:		Result:				
Current birth control/family planning method:		Are you trying to get pregnant?				
How many sexual partners in the past year:		Are you sexually active? O Yes O No				
PAST OB HISTORY						
Total pregnancies:		Number of living chil	dren:			
Number of miscarriages:		Number of voluntary	terminations:			
Number of C-Sections:		Number of vaginal de	eliveries:			
Number of tubal pregnancies:						
Complications:						
SOCIAL HISTORY						
SOCIAL HISTORY	Commonto					
Do you smoke? O Yes O No Amount per day:						
Do you drink alcohol? O Yes O No						
Amount per day?						
Have you used drugs? O Yes O No						
Do you exercise? O Yes O No						
Do you use a seat belt? O Yes O No						
Have you been emotionally, sexually, or p		Ves O No				
	oriysically abuseu? O	IES O INO				
Comments:						

Fatigue Rectal pain Arthritis Back pain Back pain Leg pain Weight gain Hernia Leg pain Pain in joints Peripheral Vascular Swelling in legs/feet Scaracts Constipation Skin Sciaucoma Diarrhea Hair loss Hair loss Pain in joints pain i	Any past surgeries?							
General/Constitutional Castrointestinal Musculoskeletal Fatigue Rectal pain Arthritis Fever Hemorrhoids Back pain Weight gain Hernia Leg pain Weight loss Indigestion Pain in joints Ophthalmologic Abdominal pain Peripheral Vascular Vision changes Blood in stool Swelling in legs/feet Cataracts Constipation Skin Glaucoma Diarrhea Hair loss ENT Nausea Venereal warts/Herpes Hearing loss Vomiting Mole(s) Balance problems Hematology Rash Hoarseness Chemotherapy Skin cancer Difficulty swallowing Anemia Neurologic Sore throat Blood disorders Lupus Endocrine Easy bruising Stroke Thyroid problems Women Only Memory problems Hormone imbalance Chlamydia/Conorrhea Dizziness Diabetes Vaginal odor Fainting	Regarding your health, ple	ase review t	he following list of health prol	olems and	desc	cribe any "yes" answers:		
Fatigue Rectal pain Arthritis Back pain Back pain Leg pain Weight gain Hernia Leg pain Pain in joints Peripheral Vascular Swelling in legs/feet Scaracts Constipation Skin Sciaucoma Diarrhea Hair loss Hair loss Pain in joints pain i		Υ	N	γ	N		Υ	N
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High cholesterol Genitourinary	Chest pain		Vaginal discharge					
	•					-		
Irregular heartbeat Blood in urine	Irregular heartbeat		Blood in urine			1		

Is there any family history in colon, uterine, breast, ovarian, or pancreatic cancer? O Yes O No Are you of Ashkenazi Jewish ancestry? O Yes O No

Urgency Frequency

Pain with urination

Involuntary loss of urine

FAMILY HEALTH HISTORY

Shortness of breath

Review the following list of health problems and check yes if they apply to parents, grandparents, siblings, aunts, uncles, or your children.

	Υ	N	If Yes, please Indicate Maternal(Mother) or Paternal (Father) Relative	If Yes, please Indicate age when diagnosed	If Yes, please Indicate Alive or Deceased?
Diabetes					
Heart Disease					
Osteoporosis					
High Blood Pressure					
Stroke					
Blood clots					
Endometriosis					
Colon cancer					
Breast cancer					
Uterine Cancer					
Ovarian cancer					
Endometrial cancer					
Birth Defects					
Other					

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