



PATIENT HISTORY

New Established

Name	Age	Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	For office use only Consult <input type="checkbox"/> Referral <input type="checkbox"/> Physician _____
Employer			
Occupation			

OB History: Pregnancies: Full term ___ Premature ___ Abortions ___ Miscarriages ___ Ectopic ___ Living Children ___

GYN History: Last Menstrual Period: _____ Method of birth control: Current _____ Past _____
Date of last PAP: _____ Any abnormal? Yes No Treatment? _____
Date of last mammogram _____ Any abnormal? Yes No Breast Biopsies? Yes No

How old were you when your periods started? _____ Are your periods: Light ___ Average ___ Heavy ___
How often are your periods? Every _____ days How many days does your period last? _____ days
Are your periods regular? Yes No Are they painful? Yes No Do you have vaginal discharge? Yes No
Do you have pain with sexual intercourse? Yes No Decreased sexual desire? Yes No Vaginal dryness? Yes No
If menopausal, Date _____ Taking Calcium? Yes No Taking Vitamin D? Yes No

Surgical History: List the year and type of surgery _____

Past Medical History: Check if you (or your family) have a history of any of these? (**Leave blank if no history**)

	Me	Family		Me	Family		Me	Family
Diethylstilbestrol (DES)	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Babies with birth defects	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots in legs	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Herpes/Genital warts	<input type="checkbox"/>	NA
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	NA
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea/Chlamydia	<input type="checkbox"/>	NA
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Elevated cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pelvic Pain	<input type="checkbox"/>	NA
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder attacks	<input type="checkbox"/>	<input type="checkbox"/>	Pelvic Infections	<input type="checkbox"/>	NA
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>						

Previous History of Anesthesia Complications? Yes No **Latex Allergies?** Yes No

Medications and dosages (including vitamins and herbals): _____

Allergies to drugs (if so give reactions): _____

Social History	Tobacco Pks/day	Alcohol Oz/wk	Coffee/Tea Cups/day	Regular Exercise?	Use Cocaine or Marijuana?
-----------------------	---------------------------	-------------------------	-------------------------------	--------------------------	----------------------------------

Are you or is anyone in your family being hit or abused or threatened? Yes No

ROS: Check if you currently have symptoms below. Leave blank if no symptoms.

Const: Weight Change Hot Flashes Fatigue **ENT:** Chronic Sinus Problems Hearing Loss Sore Throat
CV: Chest Pain Palpitations Swelling of hands or feet **Resp:** Shortness of Breath Chronic Cough Wheezing
Musk: Joint/Muscle/Back Pain **GI:** Constipation Nausea/vomiting Diarrhea Bloody stool
GU: Burning with urination Urgency with urination Unintended loss of urine Unintended loss of stool Bloody urine
Derm: Breast mass or discharge or pain Unusual hair growth Rash **Neuro:** Seizures Numbness Headache
Psy: Depression Memory Loss **Heme:** Easy Bleeding Swollen Lymph Nodes Past transfusions
End: Excessive Thirst Heat or Cold Intolerance **Other symptoms?** _____
Physician Only: All unmarked ROS are negative. _____ (Initial)

_____ Patient or Guardian's Signature	_____ Date	_____ Physician's Signature: Certifying Review of History	_____ Date
---	----------------------	---	----------------------