

PATIENT HISTORY



Date: _____ Chart #: _____ Reason for visit: _____

First Name: _____ Last Name: _____

Allergies: _____

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 box)

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					
6					
7					

CURRENT MEDICAL PROBLEMS (Describe)

1		4	
2		5	
3		6	

HOSPITALIZATIONS & OUTPATIENT SURGERIES

	Year	Reason	Doctor	Comments
1				
2				
3				
4				
5				

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? Y N # Cigarettes/day: _____

Domestic Violence (Check appropriate box): Current Past Never

Alcohol: Yes No # Drinks/week: _____ Drugs: Yes No Type: _____

Patient Signature: _____

Parent or guardian if patient is under 18