MEDICAL HISTORY FORM – Please answer all questions or mark N/A if non-applicable to you

Patient Name: ____________________ **Birthdate:** ___/____/_______ **Date:** _________________

Race: _______________ **Ethnicity:** _______________ **Primary Language:** ____________________

Reason for visit: ____

Allergies – Do you have any drug allergies? Yes / No (Circle)			
Drug	**Reaction**	**Drug**	**Reaction**

Are you allergy to Latex, Iodine or Contrast Dye? Yes / No What reaction? ___________

Please list all Medication taken: (Continue on back if necessary)

Drug	Dosage (mg)	Number of times taken per day	Drug	Dosage (mg)	Number of times taken per day

Have you ever had a blood transfusion? ☐ **Yes** ☐ **No**

Are you willing to have a blood transfusion in order to save your life? ☐ **Yes** ☐ **No**

Past Medical History: Have you ever had any of the following illnesses? Check all that apply.

☐ Heart Trouble ☐ Osteoporosis ☐ Breast Problems ☐ Nipple Discharge ☐ Diabetes
☐ Kidney ☐ Bladder Problems ☐ Anemia ☐ Hemorrhoids ☐ Anesthesia Problems
☐ High Blood Pressure ☐ Endometriosis ☐ Rectal Bleeding ☐ Antibiotics for Dental work
☐ Bleeding Problems ☐ Fibroids ☐ Heart Murmur ☐ MVP ☐ High Cholesterol
☐ Thyroid Problems ☐ Pelvic Prolapse ☐ Anxiety ☐ Blood Disorders
☐ Depression ☐ Polycystic ovarian syndrome ☐ Seizures
☐ Bowel Problems ☐ Ulcer ☐ Stomach Trouble ☐ Alcohol/Drug Abuse
☐ Lung Disease (i.e. Asthma) ☐ Blood clots in arms/legs or lungs ☐ Pelvic Prolapse
☐ Cancer (type) _____________________(age)_____________ ☐ Other ______________________________

Pap Smear History : When was your last pap smear? _________ **Where was it done?**_________
Was your last pap smear normal? ☐ **Yes** ☐ **No**
Have an abnormal one? ☐ **Yes** ☐ **No** **Treatment?** ☐ Colposcopy ☐ Leep ☐ CKC ☐ Other

Breast History : When was your last mammogram? ___________ ☐ Never
Have you ever had breast problems? ☐ Yes ☐ No What problems?_________________
Do you have breast implants? ☐ Yes ☐ No

Surgical History: Please list all surgeries (medical & cosmetic) including hospitalizations

Date	Procedure	Date	Procedure

FAMILY HISTORY: (*Please check if any of your family members have had the following; please include which relative)*

	Mother	Father	Brother	Sister	Mom's Mother	Dad's Mother	Mom's Father	Dad's Father	Aunt	Uncle
Breast Cancer										
Colon Cancer										
Ovarian Cancer										
Other Cancer Please Specify:										
Heart Disease										
High Blood Pressure										
Diabetes										
Stroke										
Other Please Specify:										

Social History Please check box and fill in the blanks

Y / N	Alcohol – Type: ☐ Occasionally ☐ Moderate ☐ Heavy
Y / N	Tobacco – Type: Amount per day: ☐ Former smoker
Y / N	Illegal drugs – Type: Amount per day:
	Religion:
	Marital History: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed
	Living situation: ☐ alone ☐ with spouse ☐ with partner ☐ with parents / custodian ☐ with children ☐ at school ☐ other
	Age 17 & Under: Diet ☐ Well Balanced ☐ Poorly Balance / Exercise ☐ None ☐ Occ . ☐ Regularly X __ per week ___ min.

Sexually activity: ☐ Never ☐ Not now but in past ☐ With one partner ☐ With more than one partner ☐ 5 or more partners in lifetime

Current birth control method (circle): Pill Patch Ring Shot Partner has vasectomy Tubal ligation Essure Adiana Hysterectomy IUD Natural Family Planning Abstinence Trying to conceive

Condom use: ☐ always ☐ most of the time ☐ rarely ☐ never

Abuse and Domestic Violence History Please check box if applies.

☐ Yes ☐ No	Were you sexually abused or molested ? ☐ As a child or teen ☐ As an adult
☐ Yes ☐ No	Are you currently being sexually abused, threatened or hurt by anyone? Whom? _________________

When was your last flu vaccine? ____________ ☐ Never

When was your last pneumonia vaccine? ________ ☐ Never

Have you ever had a bone density study? ☐ Yes ☐ No If yes, when? ________ Where?______

Patient Name:______________________________ **Date:**___________________________

Pregnancy/ Delivery History (please write them in the order they occurred)
PLEASE INCLUDE MISCARRIAGES, ECTOPIC & ELECTIVE ABORTIONS

	Born Month/year	Baby's Sex	Weight at Birth	Weeks Pregnant	Type of Delivery	Dr. who Delivered	Complications
1			Lbs oz				
2			Lbs oz				
3			Lbs oz				
4			Lbs oz				
5			Lbs oz				
6			Lbs oz				
7			Lbs oz				
8			Lbs oz				

Last Menstrual Cycle_ Date: ____/_____/_______ Do you think you are pregnant? □Yes □ No

Age at onset of menses_____ Do you have bleeding between cycles □Yes □ No

Cycles are every ____ days. Cycles last ____ days.

□ Light □ Moderate □ Heavy

Have you ever had a sexually transmitted infection: □ Yes □ No

(If yes please check which one below and write year and if treated)

STI type: □**Chlamydia-**Month/Year_____ Treatment Yes / No, □**Gonorrhea**-Month/Year_____ Treatment Yes / No,

□**Hepatitis-**Month/Year_____ Treatment Yes / No, □**HIV** -Month/Year_____ Treatment Yes / No,

□**Genital Warts-**Month/Year_____ Treatment Yes / No, □**Genital Herpes**- Month/Year_____ Treatment Yes / No,

□**Syphilis-** Month/Year_____ Treatment Yes / No, □**HPV** - Month/Year_____ Treatment Yes / No,

□**Trichomonas-** Month/Year_____ Treatment Yes / No

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Genetic Screening Includes Patient, Baby's Father, or Anyone in either Family With:					
	YES	NO		YES	NO
1. PATIENTS AGE 35 YEARS OR OLDER AS OF ESTIMATED DATE OF DELIVERY			11. MUSCULAR DYSTROPHY		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND)			12. CYSTIC FIBROSIS		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEHPALY)			13 .HUNTINGTON'S CHOREA		
4. CONGENITAL HEART DEFECT			14. MENTAL RETARDATION / AUTISM IF YES, WAS PERSON TESTED FOR FRAGILE X		
5. DOWN SYNDROME			15. OTHER INHERITED GENETIC OR CHROMAOSOMAL DISORDER		
6. TAY-SACHS (ASHKENAZI JEWISH, CAJUN, FRENCH CANADIAN)			16. MATERNAL METABOLIC DISORDER (EG, TYPE 1 DIABETES, PKU)		
7. CANAVAN DISEASE (ASHKENAZI JEWISH)			17. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
8. FAMILIAN DYSAUTONOMIA (ASHKENAZI JEWISH)			18. RECURRENT PREGNANCY LOSS, OR A STILL BIRTH		
9. SICKLE CELL DISEASE OR TRAIT (AFRICAN)			19. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS OR OTC DRUGS, ILLICIT/RECREATIONAL DRUBS, ALCHOHOL SINCE YOUR LAST MENSTRAL PERIOD IF YES TO ABOVE, STRENGTH AND DOSE		
10. HEMOPHILIA OR OTHER BLOOD DISORDERS					
			20. ANY OTHER		

Patient's Signature: _________________________________ Date: ___________________________________

Completed by (if other than patient):_______________________ Relationship: ______________________________