



I. Patient Medical History

Part I. Patient Information

Name _____ Date _____

Age _____ Date of Birth _____ Phone _____

Part 2. History of Past Illnesses

	Yes	No	Now		Yes	No	Now
Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Serious Illnesses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures or Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serious Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Yes	No	
Have you ever been hospitalized?					<input type="checkbox"/>	<input type="checkbox"/>	

If yes, please explain: _____

Do you take any medications, either prescription or over the counter?

If yes, please list names and doses: _____

Are you allergic to any medications, latex, food items?

If yes, please list: _____

Do you use vitamins, herbs or home remedies?

If yes, please list: _____

When was your last dental exam? _____

When was your last flu vaccination? _____

When was your last PPD (test for tuberculosis)? _____

Part 3. Family History

Family Member	Age	If living - health status	If deceased - age and cause of death
Father			
Mother			
Sister / Brother			
Partner			

Is anyone in your family a diabetic?



II. OB/GYN History

Name _____ Date of Birth _____

Part 4. OB/GYN History

Your age when you first had intercourse? _____

Your age when you had your first period? _____ **Yes No**

Do you have a period every month?

If no, how often? _____

How many days does your period usually last? _____

When was your last menstrual period (first day of bleeding) ? _____ **Yes No**

Are you sure?

Was your last period normal?

If no, please explain: _____

When was your last cancer (Pap) smear? _____ **Yes No**

Was it normal?

Have you ever had an abnormal Pap smear?

If yes, please explain: _____

Have you ever had: (circle if yes) Gonorrhea Chlamydia Herpes Genital Warts Syphilis

Yes No

Is this a planned pregnancy?

Is it OK to be pregnant right now?

How many living children do you have? _____

How many times have you been pregnant (including this one) ? _____

How many miscarriages have you had? _____

Have you ever had twins, triplets or more? _____

How many elective abortions have you had? _____

How many stillbirths have you had? _____

Part 5. Birth History (Please list the following details for every pregnancy you have had – for miscarriage, stillbirth, or abortion please give date only.)

Year	Term or Preemie	Vaginal or C-section	Hours of Labor	Hospital / City	Boy or Girl	Weight	Any Complications
	T P	V C-S			B G		
	T P	V C-S			B G		
	T P	V C-S			B G		
	T P	V C-S			B G		
	T P	V C-S			B G		
	T P	V C-S			B G		
	T P	V C-S			B G		
	T P	V C-S			B G		

Have you ever had any complicated or high risk pregnancies? **Yes No**

If yes, please explain: _____

Do you have concerns about your pregnancy that you would like to discuss? _____

I have answered these questions to the best of my knowledge: _____ Date: _____

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Reviewed by _____ Date: _____