

HISTORY

NAME: _____ **DATE:** ____ / ____ / ____

Menstrual History

1. What are the dates of your **last 2** menstrual periods (the first day of each)?
 1. ____ / ____ / ____
 2. ____ / ____ / ____
2. How many days does your period normally last? _____
3. How many days between periods? (count from start of period to start of next period) _____
4. Do you have any pain or cramping with your periods or during your cycle? Yes No
5. If yes, does it require medication? _____
6. Is your flow usually light, moderate or heavy? Light Moderate Heavy
7. How old were you when you had your first period? _____

Obstetrical History

1. How many pregnancies have you had? _____
2. How many were: full term _____, premature _____, miscarriages _____, abortions _____
3. Please list each pregnancy. Please include any miscarriages and/or abortions.

#	Year	Place	Duration of Gestation	Anesthesia	Duration of Labor	Type of Delivery	Weight	Sex of Baby	Complications Maternal	Complications Infant

Past Medical History

1. What is your usual Weight? _____ What is your usual Height? _____
2. Do you smoke? Yes No If yes, how much per day? _____
3. Do you drink alcoholic beverages? Yes No If yes, how often? _____
4. Have you ever used illicit drugs? Yes No If yes, please explain. _____
5. Have you ever had a blood transfusion? Yes No If yes, when? _____

Please list all non-obstetrical hospitalization, surgery and outpatient surgery.

Date	Place	Reason	Doctor

NAME: _____

6. Are you being treated for any illness or condition by any other physician? Yes No
If yes, please explain: _____

7. Are you currently taking any medications, including birth control pills? Yes No
If yes, please list: _____

8. Are you allergic to any medications? Yes No
If yes, please list: _____

9. Do you have any other allergies? Yes No
If yes, please list: _____

10. Have you ever had any of the following:

- | YES | NO | | YES | NO | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Measles | <input type="checkbox"/> | <input type="checkbox"/> | Kidney or Bladder problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Mumps | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Chicken Pox | <input type="checkbox"/> | <input type="checkbox"/> | Blood Clots in your legs or lungs |
| <input type="checkbox"/> | <input type="checkbox"/> | Migraines | <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure (hypertension) | <input type="checkbox"/> | <input type="checkbox"/> | Mental Problems or Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Blood Diseases |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease or Heart problems (including attacks) | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Diseases |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease | <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis |

Family History

Has anyone in your family (parents, grandparents, brothers, sisters) ever had any of the following?
Cancer (list relative and type of cancer) _____

Heart Disease or Heart problems that occurred before the age of 55 _____

Diabetes _____

High Blood Pressure or Stroke _____

Endometriosis _____

Any other Major Medical problems _____

Patient Signature

_____/_____/_____
Date