



MEDICAL HISTORY FORM

Please print clearly

Date _____

Name _____ Age _____ S M W D Sep _____ Occupation _____
 Husband _____ Age _____ Health _____ Occupation _____
 Contact phone # for lab results _____ Family Doctor _____
 Email Address _____

Obstetrical History:

Indicate # of:

Full Term Babies _____ Premature _____ Stillborn _____ Miscarriages _____
 Abortions _____ Number of Living Children _____

Please list your pregnancies in chronological order below

Year	Sex	WT	Vaginal or Cesarean	Hospital	Name of Child	Any Complications

Gynecological History: Age of initial menstrual period _____ Onset of last period _____
 Period every _____ days Lasting _____ days Menses reg. or irreg. _____

Any problems with periods _____

Current contraceptive method: Birth control pills (Brand) _____
 Diaphragm _____ Condoms _____ Depo Provera _____
 Norplant _____ IUD _____ Tubal _____
 Sponge _____ Vasectomy _____ Foam, Spermicides _____
 Other _____

Date of last mammogram _____ Normal or Abnormal _____

Date of last pap smear _____ Normal or Abnormal _____

Any Treatment in the Past for Abnormal Pap Smear _____

Family History: Has any blood relative ever had (please circle and indicate whom)

Birth Defects _____ Heart Disease or Attacks _____ Stroke _____
 Thyroid _____ High Blood Pressure _____ Diabetes _____
 Epilepsy _____ Mental Disorder _____ Kidney Disease _____
 Tuberculosis _____ Blood Clotting Problems _____

Relative	Age	Status of Health	Cause of Death
Mother			
Father			
Brothers			
Sisters			

PLEASE FILL OUT OTHER SIDE

