

Cleveland & Gilchrist, P.C.

Medical History Form

Name: _____

Date of Visit: _____

Date of birth: _____ Marital Status: _____ Age: _____ Primary care physician: _____

Previous gynecologist: _____ Who referred you to our office? _____

Purpose of today's visit: _____

Personal Medical History (please check all that apply):

CARDIOVASCULAR	GYNECOLOGIC	ENDOCRINE	PSYCHOLOGIC/NEUROLOGIC
Cardiac catheterization	Abnormal Pap	Adrenal gland disorder	ADHD
DVT	Bleeding after menopause	Diabetes	Anxiety
Heart attack	Chlamydia	Pituitary disease	Bipolar disorder
Heart murmur	Fibroids	Thyroid disease	Depression
Heart problems	Gonorrhea	Other:	Postpartum depression
High blood pressure	Herpes		Migraines
High Cholesterol	HPV	KIDNEY	Chronic headaches
Pulmonary embolus	Ovarian cysts	Kidney infection	Seizures
Stroke	Pelvic inflammatory disease	Kidney stones	Other:
Other:	Trichomonas	Urinary tract infection	
DIGESTIVE	Other:	Other:	OTHER
Constipation			Glaucoma
Crohn's disease	HEMATOLOGIC	MUSCULOSKELETAL	
Diarrhea	Anemia	Arthritis	PULMONARY
GERD (reflux)	B12 deficiency	Fracture	Asthma
Hepatitis	Blood transfusions	Joint pain	Chronic bronchitis
Irritable bowel syndrome	Vitamin D deficiency	Osteopenia	COPD
Stomach ulcers	Other:	Osteoporosis	Pneumonia
Ulcerative colitis		Other:	Tuberculosis
Other:			Other:
Anything else not listed above:			

Surgeries and Hospitalizations:

Reason	Year	Reason	Year

Sexual History (circle what applies):

Have you ever had sexual intercourse?	Yes	No	Number of years since onset:
Are you sexually active now (within the last year)?	Yes	No	Number of partners in the last year:
Have you ever been diagnosed with an STD?	Yes	No	Type:
What are you currently using for birth control? (Circle ALL that apply)	Birth control pills	Condoms	Implanon
	Tubal	IUD	Vasectomy
		Depo-Provera	None
		Other:	

Menstrual History:

PREMENOPAUSAL WOMEN				MENOPAUSAL WOMEN		
Age Cycle began:	Breakthrough bleeding:	Yes	No	Age of menopause:		
Date of last cycle:	Flow:	Light	Medium	Bleeding since?	Yes	No
Length of cycle:	Clots:		Yes	Hot flashes?	Yes	No
Time between cycles:	Pain/cramps:		Yes	Vaginal dryness?	Yes	No
What medications do you use for menstrual cramps:						

Social History:

Smoking	Yes	No	Packs per day:	Number of years:	Former smoker?
Alcohol	Yes	No	Drinks per day:	Drinks per week:	Number of years:
Drug Use	Yes	No	Drugs used:	Times per week:	
Regular Exercise	Yes	No	How often:		
Occupation:					

OB History (Include miscarriages & abortions. Method of delivery: C-section, forceps, vacuum, or vaginal):

Date	Method of Delivery	Weeks	Male or female?	Weight	Physician & Facility	Pregnancy Complications

Current Medications and dosage (include vitamins and herbal supplements):

Medication and dosage		Medication and dosage		Medication and dosage

Allergies: _____

Preventative Care History:

Procedure (most recent)	Date	Normal?	History of abnormal? (list treatments, i.e. LEEP, cryo, laser, cold knife cone AND year of treatment)
Pap		Yes No	Yes No
Mammogram		Yes No	Yes No
Colonoscopy		Yes No	Yes No
Bone Density		Yes No	Yes No

Does anyone in your family have a history of:

Cancer	Relative(s)	Age at diagnosis
Breast cancer		
Uterine cancer		
Ovarian cancer		
Colon cancer		
Other cancer		

To be completed by health care provider: Height _____ Weight _____ BP _____