PATIENT HISTORY FORM

Date_____

Name _____ DOB _____ Age _____

Family History		**Family Member**
Breast Cancer	N/Y	mom/dad/patGM/patGF/matGM/matGF/aunts/uncles/sibling
Ovarian Cancer	N/Y	mom/dad/patGM/patGF/matGM/matGF/aunts/uncles/sibling
Endometrial Cancer	N/Y	mom/dad/patGM/patGF/matGM/matGF/aunts/uncles/sibling
Other female cancers	N/Y	mom/dad/patGM/patGF/matGM/matGF/aunts/lincles/sibling
Lung Cancer	N/Y	mom/dad/patGM/patGF/matGM/matGF/aunts/uncles/sibling
Colon Cancer	N/Y	mom/ dad/patGM/patGF/matGM/matGF/aunts/uncles/sibling
Other Cancers	N/Y	mom/dad/patGM/patGF/matGM/matGF/aunts/uncles/sibling
Heart Disease	N/Y	mom/dad/patGM/patGF/matGM/matGF/aunts/uncles/sibling
Hypertension	N/Y	mom/dad/patGM/patGF/matGM/matGF/aunts/uncleslsibling
HIV	N/Y	mom/dad/patGM/patGF/matGM/matGF/aunts/uncles/sibling
Diabetes	N/Y	mom/dad/patGM/patGF/matGM/matGF/aunts/uncles/sibling
Alzheimer's (diag)	N/Y	mom/dad/patGM/patGF/matGM/matGF/aunts/uncles/sibling
Thyroid Disease	N/Y	mom/dad/patGM/patGF/matGM/matGF/aunts/uncles/ sibling
High Cholesterol	N/Y	mom/dad/patGM/patGF/matGM/matGF/aunts/uncles/sibling
Osteoporosis	N/Y	mom/dad/patGM/patGF/matGM/matGF/aunts/uncles/sibling

Obstetric History

Number of Pregnancies _____ Number of Deliveries _____
Number of Miscarriages/Abortions _____ Number of Children _____

Social History

Occupation:_____ _____S/D/W/Married (_____Years)
Sexually active? N/Y Condom usage? N/Y History of Recreational Drug use? N/Y
Smoker? N/Y (__pack a day) Alcohol? N/Y History of Domestic/Sexual abuse? N/Y
Do you Exercise? daily/seldom/never

GYN History

Last Menstrual Period (LMP) _____ Age at First Period? _____
How Many Days in between Periods _____ How many Days do you Bleed?_____
__

Name:_____ DOB _____ Date _____

Do you practice self breast exams each month? N/Y/Occasionally
Have you ever had a Mammogram? N/Y If Yes When?_____
When was your last Pap Smear? _____
History of Abnormal Pap Smears? N/Y When? _____
Have you had Surgery/Biopsy of your cervix? N/Y
Do you leak urine when: Exercising/Laughing/Coughing

Do you experience: Burning during urination? N/Y

Blood in your urine? N/Y
Uncontrollable loss of urine at rest? N/Y

Medical History

Height:_____Weight:_____ Drug allergies: _____

Present Medications (including over-the-counter): _____

What do you use to prevent Pregnancy? Condoms/TubesTied/Pills/Ring/Vasectomy/ Menopause
Hysterectomy /IUD/Diaphragm/Patch/ Cervical Cap/Nothing

List Anv Surgeries You've Had And Include Dates

1. _____
2. _____
3. _____
4. _____

Medical Problems: (Circle any that apply to you)
Anemia Asthma Blood Clots Bleeding Disorders Breast Mass
Cancer of any type Depression Diabetes Endometriosis High cholesterol
Heart disease High blood pressure Infertility Irritable bowel Kidney Stones
Liver Disease/Hepatitis Migraines Heart Murmur Seizure Disorder
Recurrent Bladder infections Recurrent Vaginal Infections Stomach Ulcers
Thyroid Disorders Tuberculosis Uterine Fibroids Gonorrhea Genital Warts
Syphilis Osteoporosis/Osteopenia Mitral Valve Prolapse
Ovarian Cysts Pelvic Pain Pain with intercourse Other_____
Chlamydia Herpes Psychiatric lllness