

## PATIENT HISTORY

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ M S D W Sep.

Home Address \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Phone \_\_\_\_\_

Husband's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Menstrual History: First Day Last Menstrual Period \_\_\_\_\_ Date of Last Pap Smear \_\_\_\_\_

Age at First Period \_\_\_\_\_ Length of Cycle (Start to Start) \_\_\_\_\_ Duration \_\_\_\_\_ Pain \_\_\_\_\_

Contraceptive History: Current Contraceptive \_\_\_\_\_

Previous Contraceptives \_\_\_\_\_

**Pregnancies: Total Number** \_\_\_\_\_

YEAR	LENGTH OF PREG	LENGTH OF LABOR	TYPE OF DELIV	ANESTHESIA	HOSP LOCATION	BIRTH WEIGHT	SEX	COMPLICATIONS

**Personal History Usual Weight:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **HAVE YOU AT ANY TIME HAD PROBLEMS WITH**

	Yes	No		Yes	No		Yes	No		Yes	No
Head Injury			Veins			Rheumatic Fever			Coughing Blood		
Severe Headache			Stomach			Scarlet Fever			Heart Murmur		
Seizures, Convulsions			Jaundice			Loss of Urine			High Blood Pressure		
Vision			Hepatitis, Mononucleosis			False Teeth			Cancer		
Ear, Nose, Throat			Blood in Stool			Bladder/Kidney Infection			Measles, Mumps, Chicken Pox		
Thyroid			Breast			Pain with Intercourse					
Lung Disease			Female Organs			Excessive Weight Loss					
Shortness of Breath			Syphilis, Gonorrhea			Psychiatric/Mental					
Chest Pain			Easy Bruising			Other					
German Measles			Diabetes			Irregular Menses					

### LIST ALL PREVIOUS HOSPITAL ADMISSIONS (except childbirth)

Year	Name of Hospital	Diagnosis	Treatment

### HAS ANY MEMBER OF YOUR FAMILY HAD

	Yes	No		Yes	No		Yes	No
Cancer, Leukemia			Diabetes			Epilepsy		
High Blood Pressure			Kidney Disease			Bleeding Tendencies		
Heart Trouble			Tuberculosis			Twins		

Current Medications: \_\_\_\_\_

Alcohol: Never \_\_\_\_\_ Moderate \_\_\_\_\_ Daily \_\_\_\_\_ Smoking \_\_\_\_\_ Packages per Day \_\_\_\_\_

Allergies: \_\_\_\_\_

Immunizations: dT Booster (q/10 yr) \_\_\_\_\_ Hep B Vaccine \_\_\_\_\_

Flu Vaccine \_\_\_\_\_ Pneumococcal Vaccine \_\_\_\_\_

Physician Comments: \_\_\_\_\_

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