Maternity & Gynecology Associates
Medical History Sheet

Patient Name:______________________________

Date of Birth:______________________________

PAST MEDICAL HISTORY

Check if you have ever been diagnosed with any of the following major medical problems:

	Anemia		Hepatitis
	Anxiety		High Blood Pressure
	Arrhythmia		High Cholesterol
	Arthritis		Hyperthyroidism
	Asthma		Hypothyroidism
	Bleeding Disorder		Irritable Bowel
	Blood Clot		Liver Disease
	COPD		Mental Health Concerns
	Crohn's		Migraine Headaches
	Depression		MS
	DES Exposure		Murmur
	Diabetes		Parkinson's
	Diverticulitis		Phlebitis
	Embolus		Reflux
	Fibromyalgia		Seizures
	GI Bleed		Stroke
	Glaucoma		Ulcers
	Heart Attack		
	Heart Condition, other		

STD HISTORY

Have you ever had?

	Chlamydia		Gonorrhea		HIV
	Genital Warts		Herpes		Syphilis

Any other health history we should be aware of?

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SURGICAL HISTORY

Please tell us about any past surgeries you have had *(**EXCLUDE** OB History)*

Surgery Name	Date

CURRENT MEDICATIONS

Include over-the-counter, medications, vitamins, herbal supplements- write additional on separate sheet of paper if necessary)

Medication	Dose	When Taken

MEDICATION ALLERGIES: ☐ No Drug Allergies

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Did you have the Gardasil (HPV vaccination)? Yes No

HEALTH MAINTENANCE:

Test/Procedure	Date	Test/Procedure	Date
Last Annual Exam		Last Mammogram	
Last Colonoscopy		Last Pap Smear	

Abnormal Results:

	Date(s)	Treatment?
Abnormal Pap Smear(s)		
Abnormal Mammogram(s)		

FAMILY HISTORY

Mother	ALIVE DECEASED	**Major Medical Problems:**		
Father	ALIVE DECEASED	**Major Medical Problems:**		
Siblings	ALIVE DECEASED	**Major Medical Problems:**		
Children	ALIVE DECEASED	**Major Medical Problems:**		
Other Family History:				

REPRODUCTIVE HISTORY

Age your periods began?		What is your normal cycle length? (time between periods)	days
How long is your period?	days	Flow rate	Light Medium Heavy
When was your Last Menstrual Period (date)?		Age Menopause Began?	
What do you use for Birth Control?		Are you on Hormone Replacement Therapy?	
Do you have breakthrough bleeding?			

OB HISTORY

Total # of Pregnancies		Total # of Miscarriages		Total # of Abortions	

	Date	Sex	Method of Delivery	Early Labor?	Complications	Location of Delivery
1						
2						
3						
4						
5						
6						

SOCIAL HISTORY

Tobacco Use

	Current Every Day Packs/day___________ # of Years___________		**Current Some Day**		**Former** How many years did you smoke?___________ How much did you smoke?_______________ How long ago did you quit?_______________		**Never**		**Unknown**

Alcohol Use

	Current Every Day Amount ____________		**Current Some Day** Amount ___________		**Former**		**Never**		**Unknown**

Recreational Drug Use

	Current Every Day what?___________		**Current Some Day** what? ___________		**Former**		**Never**		**Unknown**

Sexual History

Sexual Partner(s)	**Do you have any history of Abuse? YES NO**
Male Female Both	**Physical** Age:___________ by whom?_________ **Sexual** Age:___________ by whom?_________ **Emotional** Age:___________ by whom? _________ **Verbal** Age:___________ by whom? _________

To the best of my knowledge, this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary service I may need.

____ ____________________

Signature **Date**