Medical History Form

Today's Date: _____ Name: _____ Date of Birth: _____

Do You Think of Yourself as (circle): Heterosexual Homosexual Bisexual Something Else Unsure

Last Menstrual Period: _____ Any Irregular Bleeding: Yes No

Has Your Uterus Been Remove: Yes No If Yes, For What Reason: _____

Do You Still Have Ovaries: Yes No Are You On Hormone Replacement Therapy: Yes No

Allergies to Medications, Environment, or Dyes (Please Include the Reaction to All Allergies):

_____

Medications:

_____ _____ _____

What Are You Using For Birth Control: _____

Did You Receive Gardasil (HPV vaccination): Yes No

Medical History: *(Please Circle Any That Apply to YOUR Health):*

Alcoholism	Arthritis	Asthma	Blood Clot/DVT/PE	Cancer
Chlamydia	Depression	DES Exposure	Diabetes	Drug Addiction
Eating Disorder	Genital Warts	Gonorrhea	Headaches/Migraines	Heart Disease
Hepatitis	Herpes	High Blood Pressure		High Cholesterol
HIV	Kidney Disease	Lupus	Mental Health Conditions	
Osteoporosis	Seizures	Syphilis	Stroke	Thyroid Disease

If You Circled **YES** To Any Of The Above, Please Explain:

_____

_____

Surgical History: *(Please Indicate Type and Date):*

_____ _____ _____

Family History: *(Please Note The Family Member & **Maternal (M)** OR **Paternal (P)** When Appropriate):*

Breast Cancer: _____ Colon Cancer: _____

Diabetes: _____ Genetic Disorders: _____

Heart Disease: _____ High Blood Pressure: _____

Kidney Disease: _____ Lung Cancer: _____

Osteoporosis: _____ Other Cancer: _____

Ovarian Cancer: _____ Ovarian Cancer: _____

Stroke/DVT/Clotting/Bleeding Disorder: _____

Thyroid Disease: _____ Uterine Cancer: _____

Other: _____

Note The Date For The Following Tests, If Applicable:

Mammogram: _____

Colonoscopy: _____

Bone Density Scan: _____

Pregnancy History: ☐ Check If No Changes

Total Number of Pregnancies: _____

How Many Living Children: _____

Miscarriages: _____

Abortions: _____

Preterm Delivery: Yes No

Any Cesarean Sections: Yes No

Any Complications with Pregnancies: Yes No

Social History:

Do You Smoke: Yes No If Yes, Amount: _____

Do You Drink Alcohol: Yes No If Yes, Amount: _____

Any Drug Use: Yes No If Yes, Type & Amount: _____

Do You Have Any History of Abuse: Yes No If Yes, Type, Age, & By Whom: _____