Patient History

Name: _____
Date of birth: _____
Allergies to medications: _____

Marital Status: Single __ Married __ Divorced __ Widowed __ Long term relationship _
Reason for visit: _____
Occupation: _____
Preferred phone number: _____ Confidential e mails OK: Yes__ No __
Partner: _____ Age of partner: ___ Occupation of partner: _____

Menstrual History (complete even if menopausal or no longer having periods)

First day of last menstrual period: _____
Age at first period: ___
If your menstrual periods are regular; periods start every: _____ days
If your menstrual periods are irregular; periods start every: ___ to ___ days
Duration of bleeding: ___ days
Does bleeding or spotting occur between periods? Y / N
Does bleeding or spotting occur after intercourse? Y / N
Is pain associated with period? Y / N
If yes to above question, is the pain before menses or during menses or both?

Pregnancy history (all pregnancies)

Year	Place	Del type	Sex	Weight	Name	Complications

Birth control history:

What birth control method (s) do you currently use? _____

Sexual history:

Do you have a sexual partner? Y / N Male __ Female __
Are there concerns about your sexual activity which you may want to discuss with your midwife? Y / N

Past Surgical History: (including procedure and year)

Pap Smear / Mammogram History:

Date of last pap smear: _____
Have you abnormal pap smears: No / Yes / NA
Have you had treatment for abnormal pap smears: No / Yes
If yes, what type (s) of treatment have you had?
_____
Date of last mammogram: _____
Have you had an abnormal mammogram: Yes / No / NA

Other Past Gynecological History: Circle any that apply

None Venereal Warts Herpes (genital) Syphilis Pelvic Inflammatory disease
Endometriosis Chlamydia Gonorrhea Vaginal infections Other _____

Do You Currently?:
Smoke N / Y ____ packs per day
Use alcohol N / Y __wine (glasses/day) ____beer (bottles/day) ___hard liquor (oz/day)
Street drugs or prescription pain medication? N / Y Type _____ Amount _____
Exercise: Y / N Type_____ Frequency _____

Past Medical History: (Circle all that apply)

Arthritis Kidney disease Asthma High Blood Pressure Heart disease
Gallstones Liver disease (including hepatitis) Epilepsy Emphysema
Bronchitis HIV+ Eating disorder Blood transfusions Thyroid disease
Eczema Diabetes: diet controlled or pill controlled or insulin controlled
Environmental allergies (hay fever) MRSA (methicillin resistance staphylococcus aureus) None

Current Medications: (include dose and frequency)

Family History: (circle all the apply)

Diabetes Ovarian cancer Heart Disease Endometrial cancer Breast cancer
Colon cancer Thyroid disease High blood pressure Other _____

Other Symptoms
Have you recently experienced:
Weight loss Weight gain Change in energy Change in exercise tolerance
Hair loss Change in urinary function Breast discharge Hot flashes/flushing
Other _____

Fill out the questions below if you are pregnant:
Have you or the baby's father or anyone in your families ever had any of the following:

Down Syndrome? If yes, who? _____
Other Chromosomal abnormality? If yes, who? / what? _____
Neural tube defect (spina bifida, anencephaly)? If yes, who? _____
Hemophilia or other coagulation abnormality? If yes, who? _____
Muscular Dystrophy? If yes, who? _____
Cystic Fibrosis? If yes, who? _____
If you or the baby's biological father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease? Mother result _____ Father result_____
If you or the baby's biological father are of African ancestry, have either of you been screen for Sickle cell trait? Mother result _____ Father result _____
If you or the baby's biological father are of Italian, Greek or Mediterranean background, have either of you been tested for B-thalessemia? Mother _____ Father _____
If you or the baby's biological father are of Philippine or Southeast Asain ancestry, have either of you been tested for A-thalessemia? Mother _____ Father _____

Patient Signature: _____
Date: _____