Print Form

Centennial Ob/Gyn

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## Medical History

Name: Date:

MRN:

1. When was your last menstrual period?

2. ☐ Yes ☐ No Are your periods regular? How long do they usually last?

3. Please list all your pregnancies, including miscarriages and abortions:

| Date | Gestational age (weeks) | Vaginal delivery or cesarean | Birth weight | Hospital | Living (Yes or No) | Complications |
|---|---|---|---|---|---|---|
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4. Please mark any conditions that you have or have had in the past:

- ☐ Asthma
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Cancer
- ☐ Epilepsy
- ☐ Heart disease
- ☐ Kidney disease
- ☐ Endometriosis
- ☐ HIV/AIDS
- ☐ Thyroid disease
- ☐ Migraines
- ☐ Arthritis
- ☐ Frequent infections
- ☐ Bowel disease
- ☐ Hepatitis
- ☐ Fibroids
- ☐ Eating disorder
- ☐ Depression
- ☐ Anemia
- ☐ Herpes
- ☐ Sexually transmitted diseases
- ☐ Recurrent urinary tract infections
- ☐ Blood clots (Deep Venous Thrombosis)
- ☐ Lupus
- ☐ von Willebrand's disease or other bleeding disorders
- ☐ Other, please specify below

Description:

5. ☐ Yes ☐ No Are you allergic to any food or medication?

If yes, please list:

6. Please indicate any surgeries or hospitalizations:

7. ☐ Yes ☐ No Have you received blood transfusions?

If yes please indicate reason for it:

8. ☐ Yes ☐ No Do you smoke cigarettes? If former smoker, when did you quit?

How many cigarettes per day?

9. ☐ Yes ☐ No Do you drink? What type of drinks?

How often? ☐ Every day ☐ On occasions ☐ Other

10. Please list any illicit or recreational drugs ever used:

11. ☐ Yes ☐ No Do you or anyone in your family have a history of problems with anesthesia?

If yes, please describe:

12. ☐ Yes ☐ No Do you have any religious objections to any form of medical treatment (eg. blood transfusions)? If yes, please describe:

13. ☐ Yes ☐ No Are you taking any medications (including natural or herbal medications)?

If yes, please list:

| | Name | Dose | Amount (# of pills) | Frequency (# of times per day) |
|---|---|---|---|---|
| a. | | | | |
| b. | | | | |
| c. | | | | |
| d. | | | | |

14. When was your last Pap test?

☐ Yes ☐ No Have you ever had an abnormal Pap test?

If yes, when and how your were treated and what was the diagnosis:

15. ☐ Yes ☐ No Have you ever had a mammogram?

If yes, when was the last one and what was the result?

16. ☐ Yes ☐ No Have you had any close relatives with cancer (parents, grandparents, siblings, children)?

If yes, who and what type of cancer:

17. Family history:

| Relative | Current age | Age at death | Health problems or cause of death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brothers | | | |
| | | | |
| | | | |
| Sisters | | | |
| | | | |
| | | | |
| Sons | | | |
| | | | |
| | | | |
| Daughters | | | |
| | | | |
| | | | |

18. Specify the preferred pharmacy for prescriptions and major cross streets:

Patient Signature: _____ Date: