UNIVERSITY WOMEN'S HEALTH SPECIALISTS – PATIENT MEDICAL HISTORY

Patient Name:_____ Date of birth:_____ Today's Date:____/____/____

Address:_____ Phone:_____

City:_____ State/Zip:_____

Employer:_____ Insurance:_____

Primary Care Physician:_____ Referring Physician:_____

FAMILY HISTORY

Mother: ☐ Living ☐ Deceased - Cause_____ Father: ☐ Living ☐ Deceased -Cause_____

Sibling: Number Living____ Number Deceased_____ Cause(s)_____

☐ Diabetes_____ ☐ Heart Disease_____ ☐ High cholesterol_____

☐ Stroke_____ ☐ High blood pressure_____ ☐ Cancer_____

☐ Other_____

PAST HISTORY

Medical Problems/ Illnesses

_____ _____

_____ _____

_____ _____

Have you ever had a blood transfusion? ☐ No ☐ Yes If yes, when?_____

Medications - Current ☐ **none**

_____ _____

_____ _____

_____ _____

Allergies & Reactions ☐ **none**

_____ _____

_____ _____

Surgeries (procedure/date/place):

_____ _____

_____ _____

SOCIAL HISTORY

- Have you ever smoked cigarettes? ☐ No ☐ Yes
  - Do you currently smoke cigarettes? ☐ No ☐ Yes
  - How many packs per week? _____
- Do you drink alcohol? ☐ No ☐ Yes
- How many drinks per week? _____

Have you ever used illicit drugs or drugs not prescribed for you? ☐ No ☐ Yes

- Have you ever experienced domestic violence? ☐ No ☐ Yes
- Do you regularly use a seat belt? ☐ No ☐ Yes
- Do you get regular exercise? ☐ No ☐ Yes
- Marital Status: ☐M ☐ S ☐W ☐D ☐Sep
- School Completed: ☐High School ☐College ☐Graduate Degree ☐Other

PAST OBSTETRICAL/GYNECOLOGIC HISTORY

Period:Age at onset_____ : Length (days)_____ : Type ( )Heavy, ( )Light, ( )Cramps, ( )Clots

First Day of Last Menstrual Period: _____ Age at menopause:_____

History of sexually transmitted diseases: ☐ none ☐ yes_____

Contraception: ☐ none ☐ yes (type)_____

Abnormal pap smear: ☐ no ☐ yes (treatment)_____

Miscarriages ☐ none ☐ yes (number) _____ Abortions ☐ none ☐ yes (number)_____

Deliveries:	Date	Vaginal/Cesarean	Forceps/Vacuum	Sex of child	Weight

VACCINES: Chicken Pox: ☐ Infection ☐ Vaccine **Current Flu Shot:** ☐ No ☐ Yes

MY PERSONAL MEDICAL HISTORY

(check all that apply):

Gastrointestinal

- ☐ poor appetite
- ☐ abdominal pain
- ☐ indigestion
- ☐ trouble swallowing
- ☐ diarrhea
- ☐ constipation
- ☐ nausea or vomiting
- ☐ rectal bleeding or blood in stools

Cardiovascular

- ☐ chest pain
- ☐ history of angina or heart attack
- ☐ high blood pressure
- ☐ history of irregular beat
- ☐ history of poor circulation

Pulmonary/lungs

- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ asthma or wheezing

Muscle/joint/bone

- ☐ swollen joints
- ☐ joint pain/stiffness
- ☐ muscle cramps/spasm
- ☐ back pain

Neurologic

- ☐ history of stroke
- ☐ blackouts or loss of consciousness
- ☐ memory loss
- ☐ numbness/tingling

Hematologic/Lymphatic

- ☐ easy bruising
- ☐ swollen glands

General

- ☐ weight gain/loss
- ☐ poor sleep
- ☐ fever
- ☐ headache

Eyes, ears, nose, throat

- ☐ blurred vision
- ☐ history of glaucoma
- ☐ loss of hearing
- ☐ ringing in ears
- ☐ sinus problems
- ☐ hoarseness

Genitourinary

- ☐ frequent urination
- ☐ urinary retention
- ☐ blood in urine
- ☐ urinary leakage
- ☐ stool leakage
- ☐ abnormal periods
- ☐ painful intercourse

Skin

- ☐ itching
- ☐ easy bruising
- ☐ change in moles

Endocrine

- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather
- ☐ excessive thirst

Psychiatric

- ☐ depression
- ☐ anxiety

Patient:_____ Date:_____/_____/_____

Physician:_____ Date:_____/_____/_____

All unmarked 'Review of Systems' reviewed and considered negative.