



Medical History

Patient Name _____ Date of Birth _____ Date _____

What is the reason for your visit today?

Well Woman Exam – Pap smear, Breast Exam, STD Screening

I am pregnant _____ Wks LMP: _____

Consult /Concern _____

Do you take any medications? (If yes please list) None

Name of Medication	Dosage	How Often	Date Started

Do you have any allergies? None

Name of Allergen	Reaction	Date of 1 st Reaction

Do you have any medical problems? None

Medical Problem	Date of Diagnosis	Recent Lab Tests

Have you had any surgeries? None

YEAR	PROCEDURE	HOSPITAL

Have you ever been hospitalized for more than one day?(Please List) None

YEAR	NAME OF HOSPITAL	REASON



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Date of Birth

Date

Sexual History

Are you sexually active?	Yes	No	Never	My sex partners are	Men	Women	Both
Number of sex partners this year				I have a new sex partner this year	Yes	No	
Do you want to be tested for STD'S	Yes	No					

Menstrual Cycle History

What was the first day of your last menstrual cycle? ____ / ____ / ____ Started at age _____ Regular or Irregular

Menopause Yes No Age menstrual cycle ended _____ Have you had post menopause bleeding? Yes No

Pregnancy List

How many times have you been pregnant? _____ How many live births? _____

How many? Vaginal Births _____ C-Sections _____ Abortions _____ Miscarriages _____ Stillbirths _____

Birth Control History

Have you ever taken birth control? Yes No

If yes, what type of birth control have you used?

Condoms Birth Control Pills Intrauterine Device (IUD) Injection Bilateral Tubal Ligation

Social History

Do you smoke? No, Never Former Smoker Yes, Current Smoker If former or current smoker: ____ packs per day ____ years

Do you drink? No, Never Former Yes ____ drinks per _____ week

Do you do drugs? No, Never Former Yes Name _____ How long _____

Family History (Circle all that apply)

Mother Alive Deceased Unknown Healthy Heart Disease Cancer Diabetes High Blood Pressure

Father Alive Deceased Unknown Healthy Heart Disease Cancer Diabetes High Blood Pressure