SUNFLOWER OBGYN

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MEDICAL HISTORY

Last Name:		First Name:		Age:	

Please answer these questions about your previous and current health.

REASON FOR TODAY'S VISIT:

Date and Place of Last Pap Smear: _____

Date and Place of Last Mammogram: _____

Name of Primary Care Physician: _____

Past Gynecological History: *(please check off any conditions that you have had and provide dates if appropriate)*

GYNECOLOGICAL ILLNESS	YES	DATES	GYNECOLOGICAL ILLNESS	YES	DATES
Pelvic Inflammatory Disease			Fertility Problems		
Ovarian Cysts			Sexually Transmitted Infection		
Uterine Fibroids			Abnormal Pap Smear or HPV		
Endometriosis			PCOS		
Breast Disease			Other:		
Chronic Pelvic or Vulvar Pain					

Menstrual History:

Age at first menses:	If menopausal, age at last menses:
Usual Interval between periods (1st day to 1st day)?	
Usual days of bleeding with each period?	
Bleeding between periods?	
Cramping with period?	
Need for pain medication (please list):	

Miscarriage(s): please list date(s)

Termination(s) of Pregnancy: *(please list date(s), medical or surgical)*

Use of Contraception: *(please check all that apply, past and/or present)*

Oral birth control pills		IUD	
Nuvaring		Birth control patch	
Diaphragm		Depo-Provera	
Condoms		Other:	

Sexual History/Orientation or Sexual Activity: *(please write in or speak to your provider about any information or concerns you would like her to know)*

Pregnancies:

YEAR	TYPE OF DELIVERY	BIRTH WEIGHT OF INFANT	COMPLICATION

Past Surgical Procedures: *(including non-gynecological)*

YEAR	PROCEDURE	COMPLICATIONS

Medications: *(please list all current medications)*

PRESCRIPTION MEDICATION: (including OTC, herbal & vaccines)	DOSAGE

Allergies: *(please check and state type of reaction, when diagnosed)*

Penicillin	Shellfish
Sulfa Medications	Latex
Iodine	Other:

Past Medical History: *(please check any that you have had and give dates)*

PAST MEDICAL PROBLEMS	YES	DATES	PAST MEDICAL PROBLEMS	YES	DATES
Rheumatic Fever			Hepatitis		
Asthma			HIV Infection		
Epilepsy			High Blood Pressure		
Heart Disease			Bleeding/Clotting Disorders		
Mitral Valve Prolapse			Anemia		
Tuberculosis			Diabetes		
Eating Disorder (anorexia, bulimia)			Anxiety or other Psychological Issues		
Kidney problem			High Cholesterol		
Thyroid abnormalities			Depression		
Osteoporosis			Gastrointestinal Problems		
Arthritis			Bone Density		
Lupus			Colonoscopy		
Other:			Other:		

Exercise/Habits:

Do you engage in regular exercise? Yes / No
Do you smoke? Yes / No How many cigarettes per day? How many years?
How many alcoholic drinks per week?
Other recreational drug use?
Who lives in your household?

Family History: *(does/did any family member have any of the following?)*

CONDITION	RELATIONSHIP	YEAR	CONDITION	RELATIONSHIP	YEAR
Breast Cancer			Osteoporosis		
Colon Cancer			Prostate Cancer		
Ovarian Cancer			Heart Attack (under age 65)		
Uterine Cancer			High blood pressure		
Phlebitis/Clotting/Bleeding Problems			Thyroid Disease		
Diabetes			Pancreatic Cancer		
Melanoma			Other:		