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Obstetrics – Gynecology – Infertility
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PATIENT MEDICAL HISTORY

Today's Date _____

Name _____

_____ Age_____ Date of Birth _____/_____/_____

MEDICAL HISTORY

1. Are you allergic to any medicines? Yes No
If yes, what? _____

2. Are you currently taking any medications? Yes No
If yes, please list below (with dosage amount, if known):
_____
_____

3. Have you ever had an operation? Yes No
If yes, for what? _____

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

5. Do you use tobacco products? Yes No
If yes, what type and how often? _____

6. Are you currently in treatment for drug or alcohol problems? Yes No

7. Have you ever had any of the problems listed below? Yes No

(Please circle yes and all those that apply)
High blood pressure Blood clots in legs Depression
Diabetes Epilepsy Psychological problems
Heart problems Tuberculosis Visual problems
Kidney problems HIV (AIDS) Lung problems
Asthma Hepatitis (liver infection) Chicken Pox
Thyroid problems prolonged hospitalization

8. Have you ever been the victim of physical or emotional abuse? Yes No

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GYNECOLOGIC HISTORY

9. When was the first day of your last menstrual period? Give date_____

10. Age at first period? _____

11. Are your periods regular? Yes No

12. About how often do your periods come?

_____

13. About how long do your periods last?

_____

14. Are your periods painful? Yes No
If yes, do you take any medicine taken for pain? _____

15. Are you sexually active? Yes No

16. Have you been in the past? Yes No
If yes, how long have you been with your present sexual partner? _____

17. Have you ever had a Pap Smear? Yes No
If yes, when was the date of your last Pap? _____

18. Have you ever had an abnormal Pap Smear? Yes No
If yes, give date(s) _____

19. Did you receive treatment for the abnormal Pap smear? Laser Freeze LEEP

20. Have you had any of the following gynecologic problems? Yes No

(Please circle yes and those that apply)
Irregular bleeding abnormal vaginal discharge Genital warts
Bleeding between periods recurrent yeast infections Gonorrhea
Bleeding with sex burning with urination Chlamydia
Prolonged bleeding Uncontrollable leakage of urine Genital Herpes
Pain with intercourse Problems with sex drive

REPRODUCTIVE HISTORY

21. Are you sexually active at present time? Yes No

22. If yes, contraceptive method you use_____

23. If you use birth control pills, what kind? _____ ,
And for how long? _____

24. Have you ever been pregnant? Yes No

25. If yes, how many times have you been pregnant? _____

26. How many children have you had? _____

_____ Miscarriages _____ Stillbirths _____ Abortions

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Reproductive History Continued….

27. Have you had cesarean section deliveries? Yes No
28. If yes, how many? _____
29. When was your last pregnancy? _____
30. Do you plan to have more children? Yes No

FAMILY HISTORY

31. Is your father living? Yes No
If no, cause of death? _____

32. If your mother living? Yes No
If no, cause of death? _____

33. How many siblings do you have? Brothers _____ Sisters _____
34. Are they in good health? _____

35. Has anyone in your immediate and/or extended family ever had: (Circle those that apply)

Diabetes Sickle Cell anemia Mental of Physical Handicap
Elevated cholesterol Anesthesia complications Bleeding disorders
Heart attack Breast Cancer Birth defects
Stroke Ovarian Cancer Cystic Fibrosis
High blood pressure Colon Cancer Thyroid problems
Osteoporosis (weak bones)

36. Please include any other medical problems not previously listed:

_____
_____
_____
_____