

## PATIENT'S PERSONAL MEDICAL HISTORY

Date: \_\_\_\_\_

*Please complete these forms. If you do not understand any of the questions, please ask us.  
This is a confidential record. Information contained here will not be released without your prior authorization.*

Name \_\_\_\_\_ Age \_\_\_\_\_  
Last Name First Name Middle Name

Race \_\_\_\_\_ Religion (Optional) \_\_\_\_\_ Will You Accept Blood? Y N

### PERSONAL HISTORY

#### GYNECOLOGICAL HISTORY

DATE OF LAST PERIOD:	DURATION OF MENSES:	
AGE OF ONSET OF MENSES:	DAYS BETWEEN MENSES:	
	Y	N
Have you ever missed a period except when pregnant?		
Has your period ever lasted more than 8 days or less than 2 days?		
Did you ever pass large clots during your period?		
CONTRACEPTIVE HISTORY:	Y	N
Have you ever taken birth control pills?		
Are you presently taking birth control pills? If yes, which one?		
If no, what form of contraception do you use?		

#### Do you have or have you ever had any of the following conditions?

	Y	N	If yes, explain.		Y	N	If yes, explain.
Diabetes				Illicit Drug use			
High Blood Pressure				Rh Sensitization			
Heart disease				Lung/Asthma/TB			
Autoimmune disease				Seasonal Allergies			
Kidney disease/UTI				Drug/Latex Allergies			
Epilepsy/Neurological				Breast disease			
Psychiatric Problems				Anesthetic Problems			
Depression				Abnormal paps			
Hepatitis/Liver disease				Uterine Abnormalities			
Clotting/Phlebitis				Infertility			
Thyroid problems				Chicken Pox			
Trauma/Violence				Exposure to TB			
Blood Transfusion				Exposure to Herpes			
Tobacco use				Rash or viral illnesses			
Alcohol use				History of STDs			
Other				Other			

#### List all prescription and over-the-counter medications you are currently taking?

MEDICATIONS	DOSAGE	MEDICATION	DOSAGE

PREFERRED PHARMACY (Name, Location, Phone): \_\_\_\_\_

Name: \_\_\_\_\_

### GENETIC HISTORY (For Pregnant Patients Only)

**Do you, the baby's father or anyone on either side of the family have or ever had any of the following?**

	Y	N	If yes, explain.
Age over 35 years at time of delivery			
Thalassemia (Italian, Greek, Mediterranean or Asian)			
Spina Bifida, Meningomyelocele or Anencephaly			
Congenital Heart Defect			
Down Syndrome			
Tay-Sachs (Jewish, Cajun, or French Canadian)			
Canavan Disease			
Sickle Cell Disease or trait (African)			
Hemophilia or other blood disorders			
Muscular Dystrophy			
Cystic Fibrosis			
Huntington's Chorea			
Mental Retardation/ Autism			
Other inherited genetic or chromosomal disorders			
Maternal Metabolic Disorder (i.e. Type I Diabetes, PKU)			
Other birth defects from baby's father			
Recurrent pregnancy loss or stillbirth			
Exposure to medication (including supplements, vitamins, herbs, illicit drugs, alcohol) since last period.			
Exposure to chemicals or radiation (work hazards)			

### PERSONAL HISTORY (Continued)

**ALLERGIES:** List the names of any drugs to which you are allergic and state the reaction you have had:

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**OPERATIONS:** List the operations (major or minor) you have had as well as the hospital location and date:

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**ILLNESSES OR DISEASES:** List the names of any illnesses or diseases you have now or had in the past:

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**INJURIES OR ACCIDENTS:** List any serious injuries or accidents you have had and the date:

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### PERSONAL AND FAMILY CANCER HISTORY

**Do you or any member of your family have or ever had any of the following Cancer**

	Y	N	If yes, explain.		Y	N	If yes, explain.
Breast				Ovaries			
Cervix				Colon			
Uterus				Other			

PREFERRED PHARMACY (Name, location, Phone): \_\_\_\_\_

**Name:** \_\_\_\_\_

PERSONAL HABITS & PRACTICES:	Y	N	If yes,	If yes,
Do you smoke cigarettes regularly?			Packs/day?	How long?
Do you regularly drink alcohol?			Ounces/day?	How long?
			Beers/day?	How long?
Do you use any illegal drugs?			What?	Last Use?
Do you drink over 4 cups of coffee per day?			Cups/day?	How long?
Do you have a Pap smear yearly or regularly?			Date of last pap:	Normal Abnormal
Have you ever had a mammogram?			Date of last one:	Normal Abnormal
Have you ever had your cholesterol checked?			Date of last test:	Normal Abnormal
Do you perform monthly self-breast exams regularly?				

[illegible]