MEDICAL HISTORY

Patient Name: _____ **Date of Birth:** _____

Reason for Visit:

- ☐ Gynecology
- ☐ Obstetrics
- ☐ Urology
- ☐ Infertility

Past Medical History (Check any that apply):

- ☐ NONE
- ☐ Hypertension
- ☐ Rheumatology Problem
- ☐ Diabetes
- ☐ Cholesterol
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Thyroid Disease
- ☐ Anemia
- ☐ History of Abnormal Pap Smear
- ☐ Endocrinology Problems
- ☐ Gastroenterology Problems
- ☐ Eye Problems
- ☐ Urology Problems
- ☐ Neurology
- ☐ Psychological
- ☐ Pulmonary Problems
- ☐ Other _____

Gynecological History (Check any that apply):

- ☐ NONE
- ☐ First day of last period _____
- ☐ Age at first Menses _____
- ☐ Age at first Child _____
- ☐ Age at Menopause _____
- ☐ Menstrual Cycle _____
- ☐ Duration of Menstrual Cycle _____
- ☐ Birth Control Method _____
- ☐ Date of Last Pap Smear _____
- ☐ Date of Last Mammogram _____
- ☐ Date of Last Bone Density _____
- ☐ Date of Last Colonoscopy _____
- ☐ History of Endometriosis _____
- ☐ History of Fibroids _____
- ☐ History of Polycystic Ovarian Syndrome _____
- ☐ History of Sexually Transmitted Disease _____

Obstetrical History

- ☐ NONE
- ☐ Total Pregnancies _____
- ☐ Spontaneous Abortion _____
- ☐ Full Pregnancies _____
- ☐ Ectopic Pregnancies _____
- ☐ Twin Pregnancies _____
- ☐ Induced Abortions _____
- ☐ Premature Deliveries _____
- ☐ Living _____

Past Pregnancies

Date of Birth	Number of Fetuses	Weeks at Delivery	Birth Weight	Sex	Delivery Type	Anesthesia	Hospital

KENDALL
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WEST KENDALL
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WEST KENDALL OBGYN

MEDICAL HISTORY

Current Medication (Name & Dosage):

- ☐ NONE
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Allergies and Reaction

- ☐ NONE
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Social History

- ☐ Smoking Status: __ Current __ Former __Never
- ☐ Illicit Drugs: __ Yes __ No
- ☐ Alcohol Intake: __ Occasional __ Moderate __ Heavy __ None
- ☐ Caffeine Intake: __ Occasional __ Moderate __ Heavy __ None
- ☐ Exercise Level: __ Occasional __ Moderate __ Heavy __ None
- ☐ Marital Status: __ Single __ Married __ Divorced __ Widowed __ Domestic Partner
- ☐ Education: __ High School __ College __ Post-Graduate
- ☐ Occupation: _____
- ☐ Is blood transfusion accepted in case of an emergency?: __Yes __No
- ☐ Religion: _____

Family History (Check any that apply):

- ☐ NONE
- ☐ Cancer _____
- ☐ Breast _____
- ☐ Cervical _____
- ☐ Ovarian _____
- ☐ Colon _____
- ☐ Uterine _____
- ☐ Diabetes_____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Osteoporosis _____
- ☐ Thyroid Disease _____
- ☐ Other _____

Surgical History (Check any that apply):

- ☐ NONE
- ☐ Breast Augmentation
- ☐ Breast Reduction
- ☐ Plastic Surgery
- ☐ Hysterectomy
- ☐ Ovary Removal
- ☐ Tonsillectomy / Adenoids
- ☐ Cholecystectomy
- ☐ Cardiac Surgery
- ☐ Abdominal Surgery
- ☐ Bladder Surgery
- ☐ Colposcopy
- ☐ Dilation and Curettage
- ☐ Endometrial Ablation
- ☐ Tubal Ligation
- ☐ Laparoscopy
- ☐ LEEP

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