Midwest Center for Women's HealthCare

Medical History Form

DATE _____ **NAME** _____ **DATE OF BIRTH** _____

OCCUPATION _____**Primary Care Physician (name & number)** _____

WHO REFERRED YOU? _____

The following information will assist us in providing you the most excellent care. This information is a confidential record. **Please fill out both sides of this form completely.**

Have you ever had the following (circle all that apply)

Abnormal MMG	DVT/PE	High Blood Pressure	Ovarian Cyst
Abnormal Pap	Endometriosis	HIV/AIDS	Painful Periods
Anemia	Epilepsy	Irregular Vaginal Bleeding	Problem With Anesthesia
Arthritis	Fibroids-Uterus	Irritable Bowel/Colon	STD – History of
Asthma/Emphysema	Frequent Bladder Infections	Kidney Disease	Stroke
Blood Transfusion	Genetic Disorder	Liver Disorder	Thyroid - Low (Hypothyroid)
Cancer	GERD	Lupus	Thyroid - High (Hyperthyroid)
Clotting Disorder	Headaches/Migraines	Mitral Valve Prolapse	Vaginal Infections
Depression	Heart Disease	Osteopenia	Other:
Diabetes (Type I or Type II)	High Cholesterol	Osteoporosis	

Your most recent:	**Date**	**Result**	**Your most recent:**	**Date**	**Result**
Mammogram			Cholesterol Check		
PAP smear			Bone Density Scan		
Colonoscopy					

List all Surgeries and Procedures

Surgery/Procedure	**Year Performed**	**Surgery/Procedure**	**Year Performed**

List all prescription and over-the-counter medications and supplements you take regularly

Medication	Dose	Frequency (how often)	Prescribing Physician (or over the counter)

List all medication allergies and the reaction you have if you take them

Allergic To:	**Reaction**	**Allergic To:**	**Reaction**

Family History ***Are You Adopted?*** ***NO*** ***YES—if blood relative history unknown, proceed to page 2***

Has any blood relative had any of the following? *Indicate "M" for maternal, "P" for paternal family member (i.e. if your Mother's mother, write MGM)*

Problem	**Family Member** Please List**	**Age Onset**	**Problem**	**Family Member**	**Age Onset**
Anemia			Epilepsy		
Asthma			Heart Disease		
Blood Disorder			High Cholesterol		
Cancer – Breast			Hypertension		
Cancer – Colon			Kidney Disease		
Cancer – Ovarian			Migraines		
Cancer – Uterine			Stroke		
Cancer – Other			Thyroid Disorder		
Depression					
Diabetes, Type 1			Other		
Diabetes, Type II					

Gynecologic History

Age of first menstruation: _____

Menopause NO YES, since age _____

First day of most recent menstrual period: _____

How many days do your periods last?____

How often do you get your period?: _____

Do you bleed or spot between periods? NO YES

Number of sexual partners: in the last year _____

Lifetime _____

Have you ever been pregnant? NO YES

How many children have you had? _____

Are they all living? NO YES

Have you ever had a miscarriage? NO YES, how many? _____

Have you ever had an abortion? NO YES, how many? _____

Have you ever had an ectopic pregnancy? NO YES, how many? ___

Do you have any adopted children? NO YES, how many? _____

Current Birth Control Method (circle all that apply)

Virgin	Natural Family Planning	Foam/Gel	Patch	Tubal Ligation
Abstinent	Withdrawal	Diaphragm	Nuvaring	Hysterectomy
None	Condoms	IUD	Depo-Provera	No Male Partner
		Pill	Vasectomy	

Obstetric History

Date of delivery, miscarriage, abortion	# weeks at delivery	Length of labor	Sex of Baby	Type of delivery? (vaginal or C-section)	Birth Weight	Complications	Location/Doctor

Social History: **Name of Primary Physician:** _____

Marital status: Single Engaged Married Divorced Widowed

Do you smoke? Never Former—Quit when? Yes—how much per day?

Do you drink alcohol? Never Yes—how much and how often?

Do you use illegal drugs? Never Yes—what kind, how much and how often?

Do you drink caffeine? No Yes—what kind and how often?

How much exercise do you get? Sedentary 1-2 times/mo 1-2 times/wk 3-4 times/wk nearly every day daily

Do you use seatbelts? NO YES

Do you perform monthly breast self exams? NO Always Sometimes Never

Have you experienced sexual or physical abuse in the past or present? NO YES

Calcium Intake per day? # of Serving per day- ____ and/or supplements per day- _____ mg

Please circle any symptoms you are currently having, or have had recently:

Weight gain	Breast Lumps	Blood in stools	Painful periods	Anxiety
Weight loss	Nipple discharge	Fecal incontinence	Irregular periods	Depression
Chronic fatigue	Lower leg swelling	Nighttime urination	Vaginal odor	Difficulty sleeping
Persistent Fever	Varicose veins	Blood in urine	New skin lesions	Swollen lymph nodes
Cough	Diarrhea	Frequent Urination	Changes in moles	Bleed easily
Shortness of Breath	Constipation	Bladder Discomfort	Hot flashes	Frequent illnesses
Changes in Vision	Nausea	Leaking urine	Night sweats	Seasonal allergies
Neck Stiffness	Vomiting	Genital sores	Hair loss	
Frequent Headaches	Abdominal Pain	Vaginal discharge	Facial hair growth	