



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 _____

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? _____

Lifetime _____

Current Birth Control Method (circle all that apply)

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