Patient Medical History

DATE: _________ NAME: ___________________________________ DOB: ____________
AGE: __________ OCCUPATION: ____

MEDICAL HISTORY : Check if you have a personal history of:

_ Abnormal Pap Smear	_ Diabetes	_ IBS	_Urinary Tract Infection
_ Asthma	_ Gastric Reflux	_ Kidney Stone	_ Std Gonorrhea
_ Blood Transfusion	_ Heart Disease	_ Migraine	Chlamydia
_ Cancer	_ Heart Murmur	_ Osteoporosis	Genital Herpes
_ Deep Vein Thrombosis	_ Hepatitis	_ Seizures	Genital Warts
_ Depression/Anxiety	_ High Bp	_ Thrombophlebitis	Syphilis
_ DES Exposure	_ HIV/Aids	_ Thyroid Disease	_Gardasil Vaccine

Any other **MEDICAL CONDITIONS**? Yes/No List if Yes________________________
____

List all **ALLERGIES** to medications, food, or latex and reactions (nausea, hives, etc.)
____

List all current **MEDICATIONS and DOSES** (include vitamins, calcium, herbs over the counter meds). ____
____

List all **SURGERIES and DATES** ____
____
____

FAMILY HISTORY : Parents and Siblings Alive and Well? Yes/No

_ Anesthesia Problems	_ Diabetes	_ Osteoporosis	_ Birth Defects
_ Heart Attack	_ Stroke	_ Bleeding Disorders	_ Hypertension
_ Thrombophlebitis	_ Cancer	_ Mental Retardation	

List who ____
____

REVIEW OF SYSTEMS: Check all CURRENT symptoms or ______ NONE

_ Abdominal Pain	_ Headaches	_ Rashes	_ Change In Bowels
_ Heart Palpitations	_ Shortness of Breath	_ Chest Pain	_ Joint Swelling
_ Unexplained Weight	_ Cough, Sore Throat	_ Nausea Vomiting	_ Urinary Leakage
_ Depression/Anxiety	_ Night Sweats	_ Urinary Pain	_ Fevers
_ Muscle Weakness	_ Vaginal Bleeding	_ Frequent Urination	_ Pain With Intercourse

2401 Brandermill Blvd. Suite 200 • Gambrills, M.D. 21054 • Phone: 410-451-0076 • Fax: 410-451-0977
www.compgyncenter.com
SEE PAGE 2

Patient Medical History

MENSTRUAL HISTORY:
Last menstrual period (1st day)__________ Normal? Yes/No
Age of first period _______ Cycle lengths in days ______ Length of time between periods _____
Flow: Heavy/ Medium/ Light Bad Cramps? Yes/No Bleeding in between? Yes/No
Bleeding after intercourse? Ye s/No Abnormal discharge? Yes/No
Date of last Pap Smear __________ Abnormal Pap Smear? Yes/No Explain ______________
Method of contraception ____

SOCIAL HISTORY:
Marital status: Single Married Divorced Widowed Partner
Cigarettes (packs/day): ½ 1 2 never Quit/When? _________
Alcohol: never rarely weekly daily
Caffeine (cups/day) 0 1 2 3+
Recreational drugs? Yes/No
Have you been emotionally/physically abused by your partner or someone close to you? Yes/No

STUDIES:
Date of the last mammogram ______________ Normal? Yes/No
History of breast problems? Yes/No Explain ____
Date of last colonoscopy ___________ Results ____
Bone density done ________________ Results ____

OBSTETRICAL HISTORY : Fill in the chart including all deliveries, miscarriage, abortions.

Date				
Delivery: Vag, C-section, forceps, vacuum, D&C				
Complications (bleeding, diabetes, hypertension, infection)				
Sex (Male or Female) name				
Weight at birth				

Office use only: H _______ W ________ BP _______ T _______ BMI _______ Urine _______

SIGNATURE ____ **DATE** __________

2401 Brandermill Blvd. Suite 200 • Gambrills, M.D. 21054 • Phone: 410-451-0076 • Fax: 410-451-0977
www.compgyncenter.com