**Medical History Form**

Today’s Date:

Name: Date of Birth:

Do You Think of Yourself as (circle): Heterosexual Homosexual Bisexual Something Else Unsure

Last Menstrual Period: Any Irregular Bleeding: Yes No

Has Your Uterus Been Remove: Yes No If Yes, For What Reason: Do You Still Have Ovaries: Yes No Are You on Hormone Replacement Therapy: Yes No

**Allergies to Medications, Environment, or Dyes** (Please Include the Reaction to All Allergies):

**Medications:**

What Are You Using For Birth Control: Did You Receive Gardasil (HPV vaccination): Yes No

**Medical History:** *(Please Circle Any That Apply to YOUR Health):*

Alcoholism Arthritis Asthma Blood Clot/DVT/PE Cancer Chlamydia Depression DES Exposure Diabetes Drug Addiction Eating Disorder Genital Warts Gonorrhea Headaches/Migraines Heart Disease Hepatitis Herpes High Blood Pressure High Cholesterol HIV Kidney Disease Lupus Mental Health Conditions

Osteoporosis Seizures Syphilis Stroke Thyroid Disease If You Circled **YES** To Any Of The Above, Please Explain:

**Surgical History:** *(Please Indicate Type and Date):*

**Family History:** *(Please Note The Family Member &* ***Maternal (M)*** *OR* ***Paternal (P)*** *When Appropriate):*

Breast Cancer: Colon Cancer: Diabetes: Genetic Disorders: Heart Disease: High Blood Pressure: Kidney Disease: Lung Cancer: Osteoporosis: \_ Other Cancer:

Ovarian Cancer: Ovarian Cancer:

Stroke/DVT/Clotting/Bleeding Disorder: Thyroid Disease: Uterine Cancer: Other: \_

If Yes, Amount:

If Yes, Amount: If Yes, Type & Amount: If Yes, Type, Age, & By Whom:

Do You Drink Alcohol: Yes No

Any Drug Use: Yes No

Do You Have Any History of Abuse: Yes No

No

**Social History:**

Do You Smoke: Yes

Total Number of Pregnancies:

How Many Living Children: Miscarriages:

Abortions: Preterm Delivery: Yes No

Any Cesarean Sections: Yes No

Any Complications with Pregnancies: Yes No

Check If No Changes

**Pregnancy History:**

**Note The Date For The Following Tests, If Applicable:** Mammogram: Colonoscopy: Bone Density Scan: