WOMANKIND
OBSTETRICS and GYNECOLOGY

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MEDICAL HISTORY FORM

Patient Name: _____ DATE : _____
***If you have a printed list of medications or health history, we will be happy to make a copy.*

Pharmacy Name: _____

Pharmacy Street Address: _____ City: _____

County: _____ State: _____ Zip Code: _____ Phone: (_____) _____ - _____

List Current Medications and Dosage for Each:

Medication	Dosage

Please list any allergies to medications, latex, dyes, etc.: _____

_____

Past Medical History: *(Please mark what applies to you)*

☐ Thyroid ☐ Heart Disease ☐ Diabetes
☐ Hypertension ☐ Sleep Apnea ☐ High Cholesterol
☐ Renal Stones ☐ Pulmonary Disease
☐ Other: _____

History of blood transfusion: ☐ Yes ☐ No History of Abnormal PAP: ☐ Yes ☐ No

Start date of last period (MM/DD/YYYY): _____/_____/☐ Frequency of period: Every _____ days Age at first period: _____

Menstrual Flow: ☐ Light ☐ Medium ☐ Heavy ☐ Clots Current method of birth control: _____

Sexually Active: ☐ Yes ☐ No Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

History of: *(Please mark what applies to you)*

☐ Yeast ☐ Chlamydia Trichomonas ☐ Herpes
☐ Bacterial Vaginosis ☐ Gonorrhea

Total Number of Pregnancies: _____ Number of Vaginal Deliveries: _____ Number of C-Sections: _____

Number of Miscarriages: _____ Number of Abortions: _____ Number of Still Births: _____ Number of Ectopic: _____

(Please continue to next page)

Date of Last Mammogram (MM/DD/YYYY): _____/_____/_____ Date of Last Colonoscopy (MM/DD/YYYY): _____/_____/_____

Date of Last Cholesterol Test (MM/DD/YYYY): _____/_____/_____ Date of Last Bone Density (MM/DD/YYYY): _____/_____/_____

Illegal Drug Use ☐ Yes ☐ No If Yes, please list: _____

Cigarette Smoker: ☐ Yes ☐ No Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Surgical History: _____

_____

Family Health History: *(Please indicate specific family member)*

_____ Breast Cancer	_____ Anemia	_____ Heart Attack
_____ Hypertension	_____ Osteoporosis	_____ High Cholesterol
_____ Ovarian Cancer	_____ Stroke	
_____ Other: _____		