HISTORY AND PHYSICAL

Name _____ **Age**_____

Is there a particular health concern you wish to discuss with the doctor? _____
_____
_____

Date of lat Pap Smear_____ Was it normal? _____
If not, please explain any testing _____
Colposcopy/LEEP/Cryo/Laser _____

First day of your last period: _____ Was it normal? _____ Previous Period: _____
Age at time of first period: _____ How many days between cycles?____ Bleeding how many days?____
Any problems or pain with period? _____ If so, explain: _____
_____
Any medication required? _____ Please list: _____
_____
_____

Current method of birth control: _____
Past methods of birth control: _____ Any problems:_____
_____
Do you need to discuss birth control today? _____
Do you need to discuss safe sex and condom usage? _____
Any history of sexually transmitted diseases? _____

Pregnancy History:
How many Full term #_____ Premature Birth #_____ Abortion: Induced #_____ Miscarriage #_____

Month/Year	# Weeks Delivery	Labor Duration	Vag or C/S	Sex	Weight	Complications?

Hospitalization:

Year	Illness/Surgery	Hospital/Surgeon	Follow-up

Are you receiving any medical treatment at this time? _____
Please explain: _____
_____

List all medication you are now taking:	Reason	Doctor

Name _____

List any drug allergies: _____

_____

Medical History	Patient	Family Member	Comment
High Blood Pressure			
Heart Attack/Stroke			
Palpitations			
Chest Pain			
Dizziness			
Eye Problems			
Ear, Nose, Throat Problems			
Headaches/Migraine			
Asthma/Hay Fever			
Breast Disease/Breast Cancer			
Jaundice/Hepatitis			
Bowel Disorders/Cancer			
Urinary Tract Infections			
Blood in Urine			
Anemia/Heredity Blood Disorders			
Varicose Veins/Phlebitis			
Diabetes			
Thyroid Problems			
Epilepsy/Neurological Disorders			
Cancer Tumor			
Psychological Problems			
Arthritis			

Habits	Amount/Type	Per Day/Per Week
Alcohol		
Smoking		
Drugs		

Do you know how to examine your breasts? _____
Do you do the exam? _____
Date of last mammography: _____

IF YOU ARE ATTEMPTING TO GET PREGNANT:
Are you immune to: Rubella (German Measles) _____
Rubeola (Measles) _____
Varicella (Chicken Pox) _____
Do you own a cat and change its litter box? _____
Do you eat raw meat? _____
Currently taking a multivitamin that includes Folic Acid? _____
Aware of genetic screening that is available depending on family background? _____
Tay Sachs, Sickle Cell, Thalassernia _____

Please state any particular concerns: _____
_____
_____