CREEKSIDE WOMEN'S CARE
OBSTETRICS • GYNECOLOGY • INFERTILITY

MEDICAL HISTORY

Name: _____ Age: _____ Date: _____

Problems and Reasons for visit: _____

_____

GYN SYSTEM REVIEW

Menses

Age at onset of period: _____ Date of last period: _____

Are your periods regular: ☐ Yes ☐ No

How often are they: _____ How long do they last: _____

Number of pads used on your heaviest day: _____ Date of last pap: _____

Do you have bleeding after intercourse: ☐ Yes ☐ No

Do you have significant pain with your period: ☐ Yes ☐ No

Do you take pain medication: ☐ Yes ☐ No

If yes, what do you take: _____

Do you miss work monthly: ☐ Yes ☐ No

Do you have a chronic or persistent discharge: ☐ Yes ☐ No

(Circle applicable one(s)) Do you ITCH BURN HAVE AN ODOR

BIRTH CONTROL METHODS

What are you using now for birth control: _____

If you are using birth control pill; what brand: _____

What type of birth control have you used in the past (including; condoms, BTL, etc.): _____

Do you have pain with intercourse: ☐ Yes ☐ No

Do you have any problems with sexual functions: ☐ Yes ☐ No

BREAST INFORMATION

Have you had any of the following: Masses and/or lumps ☐ Yes ☐ No

Do you have any breast discharge: ☐ Yes ☐ No

Have you had a mammogram: ☐ Yes ☐ No

If yes, when was your last one: _____

MISCARRIAGES (S) / ABORTION (S)

Dates	Length of Pregnancy	Complications	Location

DELIVERIES

Dates	Weight Gain	Length of Labor	Type of Anesthesia	Natural or Forceps	Infant Sex / Weight	Problems w/Pregnancy
_____	_____	_____	_____	_____	____ / _____	_____
_____	_____	_____	_____	_____	____ / _____	_____
_____	_____	_____	_____	_____	____ / _____	_____
_____	_____	_____	_____	_____	____ / _____	_____
_____	_____	_____	_____	_____	____ / _____	_____

G. U. SYSTEMS REVIEW

Do you have or have you had burning during urination: ☐ Yes ☐ No

Do you wet yourself involuntarily with any of the following: COUGHING LAUGHING SNEEZING RUNNING LIFTING and/or GOING UP AND DOWN STAIRS

Circle one of the following: Are they WEAK or HEAVY STREAMS

Were you a bed wetter as a child: ☐ Yes ☐ No

Do you have frequent bladder or kidney infections: ☐ Yes ☐ No

Have you seen a urologist: ☐ Yes ☐ No

Have you ever had kidney stones: ☐ Yes ☐ No

Have you ever had kidney x-rays: ☐ Yes ☐ No

G. I. SYSTEMS REVIEW

Have you had any weight changes: ☐ Yes ☐ No

If yes, how much: _____ when: _____

Are you chronically constipated: ☐ Yes ☐ No

Have you had any change in bowel habits: ☐ Yes ☐ No

Do you take laxatives: ☐ Yes ☐ No

If yes, how often do you take them: _____

Do you have blood in your stools: ☐ Yes ☐ No

Do you have frequent / chronic diarrhea ☐ Yes ☐ No

Do you have ulcers: ☐ Yes ☐ No

Do you have gall bladder disease: ☐ Yes ☐ No

Do you have intestinal / stomach disorders: ☐ Yes ☐ No

Do you have frequent / chronic nausea / vomiting: ☐ Yes ☐ No

ALLERGIES

Have you ever taken penicillin: ☐ Yes ☐ No

Are you allergic to any drugs / medications: *(List below)*

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

PATIENT HISTORY INFORMATION - PAGE THREE

GENERAL HEALTH INFORMATION

Do you smoke: ☐Yes ☐No
If yes, how many per day:

Do you drink regularly: ☐Yes ☐No
If yes, how often / how much:

Do you take any other drugs: ☐Yes ☐No
If yes, what:

PAST MEDICAL HISTORY (If yes, indicate dates, treatment and by whom)

Asthma: ☐Yes ☐No

High Blood Pressure: ☐Yes ☐No

Diabetes: ☐Yes ☐No

Hepatitis / Jaundice: ☐Yes ☐No

Phlebitis: ☐Yes ☐No

Migraine Headaches: ☐Yes ☐No

Depression: ☐Yes ☐No

Lung Problems: ☐Yes ☐No

Heart Disease: ☐Yes ☐No

Chronic Kidney Disease: ☐Yes ☐No

Thyroid Disease: ☐Yes ☐No

Epilepsy: ☐Yes ☐No

Psychiatric Illness: ☐Yes ☐No

Bleeding Tendencies: ☐Yes ☐No

Have you and / or your partner been diagnosed with any of the following listed:
If so, please list date / doctor consulted:

Herpes: ☐Yes ☐No

Genital Warts: ☐Yes ☐No

AIDS: ☐Yes ☐No

Syphilis: ☐Yes ☐No

Gonorrhea: ☐Yes ☐No

Chlamydia: ☐Yes ☐No

Have you ever had a transfusion(s): ☐Yes ☐No

SURGERIES AND HOSPITALIZATIONS

Date(s)	Hospital	Reason	Physician

PATIENT HISTORY INFORMATION - PAGE FOUR

FAMILY HISTORY

	Age	State of Health	Specific Medical Problems	If deceased/Age at Death and Cause
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brother	_____	_____	_____	_____
Brother	_____	_____	_____	_____
Sister	_____	_____	_____	_____
Sister	_____	_____	_____	_____

Has any of the following been diagnosed in any relative and please specify the relationship (aunts, uncles, grandparents, etc.)

Breast Cancer: _____ ☐ Yes ☐No

Other Cancers: _____ ☐ Yes ☐No

Diabetes: _____ ☐ Yes ☐No

High Blood Pressure: _____ ☐ Yes ☐No

Heart Disease / Stroke: _____ ☐ Yes ☐No

Other Medical Problems: _____ Whom _____

_____ Whom _____

_____ Whom _____

Are there any birth defects in your or your spouse's family:

_____ Whom _____ _____ Whom _____

_____ Whom _____ _____ Whom _____

Are there any multiple births in your or your spouse's family:

_____ Whom _____ _____ Whom _____

_____ Whom _____ _____ Whom _____

If there is any other pertinent medical information not previously mentioned please discuss below: