PATIENT HISTORY FORM

DATE *(UPDATE EVERY 3 YEARS)*

NAME	NAME YOU ARE CALLED
REFERRED BY *(NEW PATIENT ONLY)*	ALLERGIES

1. PREGNANCY HISTORY *(FILL IN THE NUMBER AND YEAR)*

NO.		YEAR
	Total Pregnancies	
	Vaginal Deliveries	
	Cesarean Sections	
	Miscarriages	
	Abortions	
	Ectopic Pregnancies	
	Stillbirths	
	Total Number of Living Children	

DESCRIBE ANY SERIOUS PROBLEMS WITH PREGNANCIES

2. SURGERIES / HOSPITALIZATIONS *(LIST)*

DATE	REASON

3. GYN HISTORY *(HAVE YOU HAD ANY OF THE FOLLOWING?)*

CHECK IF APPLIES OR CIRCLE **NONE**		DATE	COMMENTS / TREATMENT
	Abnormal Pap Smear		
	Cryo or LEEP of the Cervix		
	Condyloma / Genital Warts		
	Endometriosis		
	Ovarian Cysts/Tumors		
	Uterine Fibroids		
	Pelvic Inflammatory Disease (PID)		
	Sexually Transmitted Disease (STD)		
	Genital Herpes		
	Abnormal Mammogram		
	Other Gyn Problems		

4. MEDICAL HISTORY *(CHECK IF APPLIES)*

		SELF	FAMILY *(SPECIFY)*	COMMENTS
	Anemia / Blood Disorders			
	Birth Defects			
	Blood Clots / Phlebitis			
	Breast Cancer			
	Colon Cancer			
	Cancer Other / Type:			
	Diabetes			
	Emotional / Mental Problems			
	Epilepsy / Neurological			
	Gall Bladder Disease			
	Heart Disease			
	Hepatitis			
	High Blood Pressure			
	Kidney / Urinary Tract Problems			
	Migraines / Severe Headaches			
	Musculoskeletal Problems			
	Respiratory Problems / Asthma			
	Stroke			
	Thyroid Disease			
	Other:			