Glen Meade Center for Women's Health

NHRMC Physician Group

Personal Medical History

Patient Identification

Name: _____ Date of Birth: _____ Age: _____

Occupation: _____ Race: _____ Referring Physician: _____

Employer: _____ Primary Physician: _____

Reason for Visit

1 In the lines below, please describe any special problems or symptoms you would like to discuss with the doctor today:

_____

_____

_____

2 How long have you had this problem? ❑ 1 week ❑ 1 month ❑ 1 yr ❑ over 1 yr

3 What treatment have you received for this problem? _____

_____

4 Did the treatment help? ❑ yes ❑ no

Past Medical History

Place an (X) next to any of the following problems for which you or a close family member have been treated or diagnosed:
(close family member = mother, father, brother, or sister only)

	personal history	family history		personal history	family history
High blood pressure	❑	❑	Hepatitis	❑	❑
Heart attack or stroke	❑	❑	Other liver diseases	❑	❑
Disease of heart valves	❑	❑	Irritable bowel syndrome	❑	❑
Other heart disease	❑	❑	Pancreatitis	❑	❑
Asthma	❑	❑	Stomach or duodenal ulcer	❑	❑
Tuberculosis	❑	❑	Arthritis	❑	❑
Other lung disease	❑	❑	Seizure disorder	❑	❑
Melanoma	❑	❑	Depression	❑	❑
Cancer _____	❑	❑	Psychiatric disorder	❑	❑
Diabetes mellitus	❑	❑	Sexual abuse or domestic violence	❑	❑
Thyroid disease	❑	❑	Alcohol or substance abuse	❑	❑
Kidney infection	❑	❑	Anemia or blood disorder	❑	❑
Other kidney disease	❑	❑	Blood clots in lungs or legs	❑	❑
Bladder disease	❑	❑	Blood transfusion	❑	❑
Crohn's disease	❑	❑	Elevated cholesterol	❑	❑
Diverticulitis or diverticulosis	❑	❑	Other_____	❑	❑

Past Obstetric History

How many times have you been pregnant? _____

How many children have you delivered (vaginal and cesarean)? _____

How many were delivered by cesarean section? _____

How many of your children were born prematurely? _____

How many miscarriages have you had? _____

Have you ever had an abortion? ❑ yes ❑ no

If yes, how many? _____

How many ectopic pregnancies have you had? _____

How many of your children are still living? _____

How many twins or multiple births have you had? _____

Place an (X) next to any of the following complications of pregnancy which you have had:

❑ Toxemia or preeclampsia

❑ High blood pressure

❑ Gestational diabetes

❑ Blood transfusion

❑ Stillbirth

❑ Other complications_____

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Past Gynecologic History

Place an (X) next to any of the following problems for which you or a close family member have been treated or diagnosed:

	personal history	family history		personal history	family history
Fibroids or leimyomata	❑	❑	Cancer of the uterus, tubes, or ovaries	❑	❑
Infertility	❑	❑	Abnormal pap smear	❑	❑
Endometriosis	❑	❑	Breast cancer	❑	❑
Pelvic infections	❑		Breast mass or cyst	❑	❑
Sexually transmitted disease	❑		Other_____	❑	❑

Previous Surgeries

Type of operation	Date

Other Hospitalizations

	Date

Medications

List all of your current medications

Allergies

Are you allergic to any medications? ❑ yes ❑ no

Name	Type of reaction

Other Health Information

Marital status

Married ❑ Single ❑
# of yrs_____ Divorced ❑
Name of spouse Separated ❑
_____ Widowed ❑

Menstrual history

1 First day of last menstrual period _____/_____/_____
2 How often do your periods occur? _____
3 Length of period in days _____
4 Age at first period _____
5 Do you have bleeding in between your normal periods? ❑ yes ❑ no

Sexual History

1 Number of lifetime partners ❑ none ❑ one ❑ 2-5 ❑ more than 5
2 Age at first intercourse _____
3 Pain with intercourse ❑ always ❑ sometimes ❑ never
4 Have you ever been raped, sexually or physically abused? ❑ yes ❑ no

Contraception

What is your current method of contraception?

❑ Tubal ligation ❑ Hysterectomy
❑ Vasectomy ❑ IUD
❑ Diaphragm ❑ Condoms
❑ Depo-Provera ❑ Oral contraceptive pill
❑ Other _____ Which one?_____

Substance use

Do you smoke cigarettes? ❑ yes ❑ no
packs per day _____
Do you drink alcohol? ❑ yes ❑ no
amount per week _____
Have you ever used marijuana, heroin, cocaine, or other street drugs? ❑ yes ❑ no
If yes, what? _____
Are you using any of those drugs now? ❑ yes ❑ no
If yes, what? _____

Review of Systems

Are you currently having any of the following problems?

Chest pain	❑ yes	❑ no
Difficulty breathing	❑ yes	❑ no
Abdominal pain	❑ yes	❑ no
Blood in stools	❑ yes	❑ no
Constipation or loose stools	❑ yes	❑ no
Pain with urination	❑ yes	❑ no
Leaking urine	❑ yes	❑ no
Abnormal vaginal discharge	❑ yes	❑ no

Have you ever had a pap smear? ❑ yes ❑ no
If yes, when was your last? _____
Have you ever had a mammogram? ❑ yes ❑ no
If yes, when was your last? _____