Name _____ **Date**_____

Medicines:

_____ _____

_____

_____ _____

_____ _____

_____ _____

Allergies to medicines? _____

If so, to what medicines?

_____

Social history:

Occupation:

Smoke: ____ If so, how much? ____

Alcohol: ____ If so, how much? ___

Drugs _____

Review of Systems--Place a check if you have had a recent problem in:

1. Weight loss greater than 10 pounds_____
2. Bad skin rashes or itching_____
3. Bad headaches_____
4. Blurred vision or visual problems_____
5. Diabetes _____
6. High blood pressure_____
7. Heart trouble_____
8. Rheumatic fever_____
9. Heart murmur_____
10. Chest pain_____
11. Palpitations_____
12. Asthma_____
13. Shortness of breath _____
14. Tuberculosis_____
15. Gall bladder problems_____
16. Breast lumps or pain_____
17. Hepatitis_____
18. Liver trouble_____
19. Ulcers_____
20. Stomach pain_____
21. Colitis_____
22. Excessive diarrhea_____
23. Constant constipation_____
24. Bright red blood in stools_____
25. Black, tar-like stools_____
26. Bladder infections_____
27. Kidney infection_____
28. Kidney stones_____
29. Stop bleeding when cut_____
30. Blood clot in legs or lungs_____
31. Depression or mental illness_____

Past Surgery

_____

_____

_____

_____

_____

_____

Past Medical History

Obstetric History (include all pregnancies starting from first)

1._____
2. _____
3. _____
4. _____
5. Date of last pap smear _____ Abnormal pap ever? _____

Do you have any reason to believe you could have HIV? ____

Have you ever been hurt (physically or mentally) by your partner?_____

Gynecologic History

1. Age of first menstrual period _____
2. Length of period (in days) _____
3. Cramps: Mild__ Moderate __ Severe __
4. Interval (from first day of one period to _____ the first day of next period) ____ _____
6. Have you ever had chlamydia? ___ gonorrhea? ___
7. Have you ever had a mammogram? _____
8. Have you had a bone mineral density? __

Genetic History

Name _____ **Date**_____

Are any of your blood relatives:		Your partner's family (if desiring fertility):
English, Irish:	Yes ___ No ___	Yes ___ No ___
Mediterranean: (Greek, Italian)	Yes ___ No ___	Yes ___ No ___
Ashkenazi Jewish:	Yes ___ No ___	Yes ___ No ___
French Canadian:	Yes ___ No ___	Yes ___ No ___
African Descent:	Yes ___ No ___	Yes ___ No ___
Does anyone in your family have:		Your partner's family
Mental retardation:	Yes ___ No ___	Yes ___ No ___
Down syndrome:	Yes ___ No ___	Yes ___ No ___
Open spine defects (spina bifida, anencephaly)	Yes ___ No ___	Yes ___ No ___
Cystic fibrosis:	Yes ___ No ___	Yes ___ No ___

Patient Label

Sickle cell anemia:	Yes ___ No ___	Yes ___ No ___
Thalassemia:	Yes ___ No ___	Yes ___ No ___
Cancer:	Yes ___ No ___	Yes ___ No ___
Birth defects:	Yes ___ No ___	Yes ___ No ___
Diabetes:	Yes ___ No ___	Yes ___ No ___
Heart Disease	Yes ___ No ___	Yes ___ No ___
Stroke:	Yes ___ No ___	Yes ___ No ___

Please do not write below this line.