Fulton Center for Women's Health

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MEDICAL HISTORY FORM

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Name _____ Date _____
Last Name First Name Middle Name

DOB _____ Age _____ Race _____

Primary Care Provider/Family Medicine Physician _____

Family History

	If Living			If Deceased	
	sex	Age	health	Age at Death	Cause
Father					
Mother					
Brothers/Sisters	M/F				
	M/F				
	M/F				
	M/F				
	M/F				
	M/F				
	M/F				
Husband					
Sons/Daughters	M/F				
	M/F				
	M/F				
	M/F				

Medical History

(family or self)

Do you or any members of your family have or ever had any of the following? (circle and give relation)

Asthma Y/N: _____
Diabetes Y/N: _____
Hepatitis Y/N: _____
Bleeding disorders Y/N: _____
Cystic Fibrosis Y/N: _____
Mental Retardation Y/N: _____
Downs Syndrome Y/N: _____
Hydrocephalus/Spina Bifida Y/N: _____
Tay Sachs Y/N: _____
Colitis/Gastric Ulcers Y/N: _____

Epilepsy Y/N: _____
Heart Disease Y/N: _____
High Cholesterol Y/N: _____
Heart Defects Y/N: _____
High Blood Pressure Y/N: _____
Stroke Y/N: _____
Herpes Y/N: _____
Goiter/Thyroid problems Y/N: _____
Congenital Defects Y/N: _____
Sexually Transmitted Diseases Y/N: _____

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Your previous surgeries (hospital location/date): _____

_____

Your previous diseases or illnesses (past or present): _____

_____

_____

_____

Your serious injuries or accidents: _____

_____

_____

Cancers

(family or self)

Breast Y/N: _____ Uterus Y/N: _____

Cervix Y/N: _____ Ovaries Y/N: _____

Other Y/N: _____

Medications

Are you presently taking any of the following medications? (circle)

Aspirin, Bufferin, Anacin	Yes	No	Tranquilizers	Yes	No
Blood pressure pills	Yes	No	Weight Loss	Yes	No
Cortisone	Yes	No	Blood thinners	Yes	No
Cough medicine	Yes	No	Dilantin	Yes	No
Digitalis (heart pills)	Yes	No	Shots	Yes	No
Hormones	Yes	No	Water pills	Yes	No
Insulin or diabetic pills	Yes	No	Antibiotics	Yes	No
Iron	Yes	No	Barbiturates	Yes	No
Laxatives	Yes	No	Birth control pills: _____	Yes	No
Sleeping pills	Yes	No	Phenobarbital	Yes	No
Thyroid pills	Yes	No	Other dugs not listed (including vitamins, herbs, over the counter)	Yes	No

Please list any other medications: _____

_____

Allergies/Reaction: _____

_____

Menstrual History

First day of last menstrual period _____ Duration of menses _____

Interval between menses _____ Age at onset of menses _____

Have you ever missed a period except when pregnant? Yes/No

Has your period ever lasted more than eight days or less than two days? Yes/No

Have you ever passed large clots during your period? Yes/No

Contraceptive History

Have you ever taken birth control pills? Yes/No

Are you presently taking birth control pills? Yes/No

If yes to above question, list brand of birth control pills: _____

If no, what form of contraception do you use? _____

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Other

Do you have any urinary problems? Yes/No
If yes to above, please explain: _____
Do you have varicose veins? Yes/No
Do you have phlebitis or inflamed leg veins? Yes/No

Personal Habits and Practices

Do you regularly smoke or use nicotine? Yes/No
If yes to above: Cigarettes/day: _____ Packs/Day: _____ For how many years? _____
Do you usually drink over 4 cups of coffee or caffeinated beverages per day? Yes/No
Do you regularly drink alcohol? Yes/No
If yes to above, how much? _____
Do you regularly drink beer? Yes/No
If yes to above, how much? _____
Do you regularly have a pap smear? Yes/No
Have you ever had an abnormal pap smear? Yes/No
If yes, please explain what measures were taken following the abnormal pap smear result _____

Do you regularly perform monthly breast self-examination? Yes/No
Have you ever had a mammogram? Yes/No
If yes to above, list date and results of last mammogram: _____
Have you ever had your cholesterol checked? Yes/No
If yes to above, list date and results: _____
Have you ever had a bone density test? Yes/No
If yes to above, list date and result: _____
Have you ever had a colonoscopy? Yes/No
If yes to above, list date and result: _____
Do you now, or have you in the past, used illegal drugs? Yes/No

Obstetric History

(including miscarriages and elective abortions)

Date of Delivery	Full Term/Pre-term/Abortion	Vaginal/C-Section Delivery	Hours in Labor	Sex/Birth Weight	Complications for Either Mother and/or Baby