COPPERSTATE OB/GYN ASSOCIATES LTD.

Women's Health Specialists

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MEDICAL HISTORY

Name_____ Age _____

Date of Birth_____/_____/_____

Referring Doctor_____ Marital Status _____

Today's Date_____/_____/_____

Reason for seeing Doctor: [ ] Annual Exam Other: _____

I GYN History:

1. 1st day of last menstrual period ___/___/___ ☐ Regular ☐ Irregular ☐ Heavy Bleeding
2. What are you using to prevent pregnancy, if needed?_____
3. When was your last PAP smear (recommended yearly)? _____/_____
4. Have you ever had an abnormal PAP smear? ☐ Yes ☐ No
5. When was your last Mammogram (recommended after 40)? _____/_____
6. If you are menopausal, are you taking hormone replacement? ☐ Yes ☐ No
7. Do you experience urine leakage? ☐ Yes ☐ No

Doctor's Comments

II Pregnancy History: (Please list the number)

Term Birth_____ Premature Birth_____ Miscarriages _____ Abortions _____
Living Children_____

#	Born Mos/Day/Yr	Weight lb oz	Sex	Weeks Preg.	Type of Delivery	Complications Yes	Complications No
1						☐	☐
2						☐	☐
3						☐	☐
4						☐	☐
5						☐	☐

II Medical History:

1. Do you have any medical illnesses? (please list) ☐ None

_____ _____
_____ _____
_____ _____

2. Medications: (please list name & dose) ☐ None

_____ _____
_____ _____
_____ _____

3. What medications are you allergic or had a reaction to? ☐ none

_____ _____
_____ _____
_____ _____

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Medical History (continued)

IV. Surgical & Hospitalization History: [ ] None:

Date Mos/Yr	Operation or Illness	Complications Yes	Complications No
/		☐	☐
/		☐	☐
/		☐	☐
/		☐	☐
/		☐	☐

Doctor's Comments

V. Family History:

Do any 1st degree family members (parents, sister, or children) have the following?

	Yes	No	Who?
Breast Cancer	☐	☐	_____
Cancer of Reproductive Organs	☐	☐	_____
Colon Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Attack / Stroke	☐	☐	_____

VI. Social History:

1. What is your occupation? _____

	Yes	No
2. Do you smoke cigarettes?	☐	☐
2a. Number of cigarettes per day _____		
3. Do you drink alcohol?	☐	☐
4. Have you used recreational drugs in the past 5 years?	☐	☐
5. Has anyone threatened or hurt you in the last year?	☐	☐

VII. Sexual History:

1. Number of sexual partners in the past year? Male_____ Female_____

	Yes	No
2. Have you ever had any sexually transmitted disease? (eg. Herpes, Gonorrhea, Chlamydia, Genital Warts)	☐	☐
3. Do you have any concerns about your sex life that you wish to discuss?	☐	☐

VIII. Dietary & Exercise History:

1. How many servings of dairy products do you eat in an average day? _____

	Yes	No
2. Are you currently dieting?	☐	☐
3. Do you exercise regularly?	☐	☐

Type(s)_____