Request for Medical History

WESTERN
Gynecological and Obstetrical Clinic, Inc.
Total Women's Health Care

Name: _____

Date of Birth: _____

Maiden Name: _____ Marital Status: _____ Today's Date: _____

Address: _____ Home Phone: _____ Work Phone: _____

Occupation: _____ Age: _____

Primary Care Physician: _____

Last Annual Checkup: _____

Allergies: _____

_____

Operations (Include dates): _____

_____

_____

Serious Injuries: _____

_____

Major medical problems or other hospitalizations (Include dates): _____

_____

_____

_____

Family History Specify relative? (parents, grandparents, brothers, sisters, children)

Heart disease or high cholesterol: _____

Diabetes: _____

Cancer:

Breast: _____

Ovarian: _____

Colon: _____

Other: _____

Skin: _____

Thyroid Disease: _____

Blood clots in veins (Legs or lungs): _____

Do you:	Currently	Previously	No
Smoke?	☐	☐	☐
Use alcohol?	☐	☐	☐
Use drugs socially?	☐	☐	☐
Use Diet Pills?	☐	☐	☐

Number of times pregnant: _____

Number of deliveries full term: _____

Pre-term (Less than 37 weeks): _____

Number of pregnancy losses (miscarriages, tubal pregnancies, abortions, etc.): _____

Number of living children: _____

Number of cesarean deliveries: _____

Complications of pregnancy (Including diabetes): _____

_____

Current method of contraception, if any (Including vasectomy): _____

Date last menstrual period began: _____

Age when periods started: _____

Periods start every _____ **days and last** _____ **days.**

Age when periods stopped (if menopausal): _____

When was your last Pap test? _____

Date of last mammogram: _____

Are your cycles regular? YES ☐ NO ☐

Are heavy periods a problem? YES ☐ NO ☐

Have you had an abnormal Pap test? YES ☐ NO ☐

Are you current on immunizations? YES ☐ NO ☐

Have you had:	Currently	Previously	No
Vaginal infection?	☐	☐	☐
Pelvic infection?	☐	☐	☐
Pain with periods?	☐	☐	☐
Pain with intercourse?	☐	☐	☐
Herpes?	☐	☐	☐
Gonorrhea?	☐	☐	☐
Syphilis?	☐	☐	☐
Chlamydia?	☐	☐	☐
Involuntary loss of urine?	☐	☐	☐
Genital Warts	☐	☐	☐
A breast lump or mass?	☐	☐	☐

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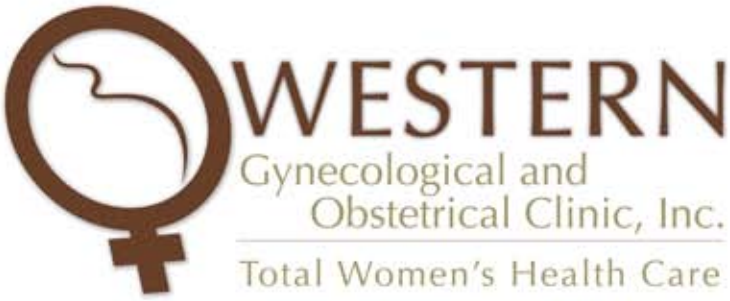

Name: _____

Date of Birth: _____

	Current	Previous	No
Chest pain	☐	☐	☐
High blood pressure	☐	☐	☐
Heart attack	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Born with a heart condition	☐	☐	☐
Pounding heart (palpitations)	☐	☐	☐
Other heart problem	☐	☐	☐
Rheumatic fever	☐	☐	☐
Shortness of breath at rest	☐	☐	☐
Persistent cough	☐	☐	☐
Pneumonia	☐	☐	☐
Recurrent or chronic bronchitis	☐	☐	☐
Asthma	☐	☐	☐
Wheezing	☐	☐	☐
Other respiratory problem	☐	☐	☐
Indigestion/Heartburn	☐	☐	☐
Upper abdominal pain	☐	☐	☐
Ulcer	☐	☐	☐
Gall bladder trouble	☐	☐	☐
Much nausea/vomiting	☐	☐	☐
Much diarrhea	☐	☐	☐
Much constipation	☐	☐	☐
Hemorrhoids	☐	☐	☐
Blood with stools	☐	☐	☐
Other intestinal problems	☐	☐	☐
Liver disease	☐	☐	☐
Jaundice (yellow skin)	☐	☐	☐
Bladder or kidney infection	☐	☐	☐
Urinary urgency/frequency	☐	☐	☐
Burning with urination	☐	☐	☐
Other kidney/bladder problems	☐	☐	☐
Broken/fractured bones	☐	☐	☐
Muscle pain	☐	☐	☐
Back pain	☐	☐	☐
Joint pain	☐	☐	☐
Arthritis	☐	☐	☐
Tremor	☐	☐	☐
Pre-cancer or cancer	☐	☐	☐

What kind? _____

	Current	Previous	No
Glasses	☐	☐	☐
Contact lenses	☐	☐	☐
Partial/complete dentures	☐	☐	☐
Ear infections	☐	☐	☐
Decreased hearing	☐	☐	☐
Unusually frequent colds	☐	☐	☐
Swollen lymph nodes	☐	☐	☐
Transfusion	☐	☐	☐
Anemia (low blood count)	☐	☐	☐
Blood clots in veins (legs or lungs)	☐	☐	☐
Phlebitis (inflammation of veins)	☐	☐	☐
Easy bleeding/hemophilia	☐	☐	☐
Other blood problems (sickle cell, etc.)	☐	☐	☐
Hepatitis	☐	☐	☐
Been knocked out	☐	☐	☐
Passed out	☐	☐	☐
Seizures/convulsions	☐	☐	☐
Severe headaches	☐	☐	☐
Many headaches	☐	☐	☐
Depression	☐	☐	☐
Post Partum Depression (severe baby blues)	☐	☐	☐
Anxiety	☐	☐	☐
Other nervous system condition	☐	☐	☐
Insomnia	☐	☐	☐
Fatigue	☐	☐	☐
PMS/PMDD	☐	☐	☐
Thyroid problems	☐	☐	☐
Diabetes (High blood sugar)	☐	☐	☐
	☐	☐	☐
Other medical conditions:			
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

Medicines you are presently using, with dose and frequency (include non-prescription also, such as aspirin)

_____

_____

_____

_____

_____

Signature of person completing form

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