## Confidential Medical History

### Patient Name: ___________________________  Date: ___________________________

**Race:**
- [ ] African American
- [ ] Asian
- [ ] Caucasian
- [ ] Hispanic
- [ ] Other

### Past Medical History

**Gynecological History:**
- [ ] Abnormal Pap Smear
- [ ] Hx of STD
- [ ] Cervical Cancer
- [ ] Menopausal Symptoms
- [ ] Cervical Dysplasia
- [ ] Performance of Monthly Self Breast Exams
- [ ] Cervical Polyp
- [ ] Uterine Prolapse
- [ ] Endometriosis
- [ ] Vaginal Prolapse
- [ ] Irregular Menses
- [ ] Other

**Breast History:**
- [ ] Abnormal Mammogram
- [ ] Breast Cysts / Mass
- [ ] Breast Cancer
- [ ] Other:

**Cardiovascular History:**
- [ ] Cardiac Arrest
- [ ] Mitral Valve Prolapse
- [ ] Hypertension
- [ ] Phlebitis
- [ ] Deep Venous Thrombosis
- [ ] Transient Ischemic Attack
- [ ] Heart Murmur
- [ ] Other:

**Endocrinology History:**
- [ ] Crohn's Disease
- [ ] Hypothyroidism
- [ ] Diabetes
- [ ] Ovarian Dysfunction
- [ ] High Cholesterol
- [ ] Vitamin Deficiency
- [ ] Hyperthyroidism
- [ ] Other:

**Hematologic History:**
- [ ] Anemia
- [ ] Other:

**Psychiatric History:**
- [ ] Anxiety
- [ ] Depression
- [ ] Other:

**Patient Signature: __________________________________________________________
### Confidential Medical History

#### Surgical History:

Please Indicate Any Surgical Procedure You Have Undergone As Well The Year

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Location</th>
<th>Year</th>
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#### Medications:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Prescribed By</th>
<th>Dose</th>
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#### Allergies:

Please List All Medication Allergies

<table>
<thead>
<tr>
<th>Medication</th>
<th>Symptoms / Reactions</th>
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#### Family Medical History:

Please Mark All That Apply and Give Relation

<table>
<thead>
<tr>
<th>Condition</th>
<th>Relation</th>
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<tbody>
<tr>
<td>Breast Cancer</td>
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<tr>
<td>Cervical Cancer</td>
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<tr>
<td>Ovarian Cancer</td>
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<tr>
<td>Uterine Cancer</td>
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<td>DVT</td>
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<tr>
<td>Diabetes</td>
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<td>Glaucoma</td>
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<td>Heart Disease</td>
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<td>Hypertension</td>
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<td>Multiple Births</td>
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<td>Osteopenia</td>
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Patient Signature: __________________________________________________________
## Menstrual History:

<table>
<thead>
<tr>
<th>Age of Onset</th>
<th>Last Menstrual Period</th>
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<tbody>
<tr>
<td>Cycle Duration</td>
<td>If Menopausal, year menses stopped</td>
</tr>
<tr>
<td>Cycle Interval</td>
<td></td>
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</tbody>
</table>

## Obstetrical History:

<table>
<thead>
<tr>
<th>Date</th>
<th>Hospital</th>
<th>Sex</th>
<th>Type of Delivery</th>
<th>Infant Weight</th>
<th>Months</th>
<th>Complications</th>
</tr>
</thead>
</table>

Please Mark All That Apply

- Breech Delivery
- Pre-Term Labor
- Cervical Incompetence
- Post Partum Depression
- Ectopic
- Termination
- Gestational Diabetes
- Other
- Infertility
- Miscarriage

## Social History:

Please Mark All That Apply

- Alcohol Use
- Multiple Sexual Partners
- Illicit Drug Use
- New Sexual Partner
- Increased Risk of Infection
- Other

## Exercise Regimen:

- Active: (4 or More Days Weekly)
- Physical Abuse
- Moderate: (1 - 3 Days Weekly)
- Emotional Abuse
- Minimal: (1 Day a Week)
- SEDENTARY

## Religion:

- Christian
- Jewish
- Muslim
- Jehovah Witness
- Hindu
- Other

Patient Signature: ________________________________