WGM OB/GYN P.C.
PATIENT MEDICAL HISTORY Date:________________________, 20______

NAME____ AGE _____________ DOB_____________________

MENSTRUAL HISTORY:

Age Began: __________________ Frequency: ________________________ Last Menses: _______________________

CONTRACEPTION:

Are you currently sexually active? __________ Male? __________ Female? __________ Both? ___________
What method are you currently using? ____
Have you ever used? Pills____Diaphragm___IUD____Depo____Nuvaring_____Implant _____Sterilization____
Do you use condoms? ____________________

OBSTETRICAL HISTORY:

Year & Hospital	Sex	Weight	Vaginal or C-section Delivery	Any prenatal complications or problems with your delivery?
__________________	______	__________	_________________	_______________________________________
__________________	______	__________	_________________	_______________________________________
__________________	______	__________	_________________	_______________________________________

MISCARRIAGES OR ABORTIONS:

Year	Hospital/Clinic	Doctor	Problems
_________	_______________________________	_________________	________________________________
_________	_______________________________	_________________	________________________________
_________	_______________________________	_________________	________________________________

GYN SURGERY:

Procedure	Doctor	Hospital/Year
____	__________________	_________________________/______
____	__________________	_________________________/______
____	__________________	_________________________/______

GYNECOLOGIC HISTORY:

Have you ever had or been diagnosed with any following? (if yes, please provide details)
Abnormal Pap smear____
Fibroids ____
Ovarian cysts ____
STD's Chlamydia_________ Gonorrhea __________ Condyloma (genital warts) _________ Herpes___________
Date of last mammogram (month/year)____
Date of last Pap smear (month/year)____
Have you ever had the Gardasil vaccination? ______________________________ If yes, when? ________________

NAME___________________________________

GENERAL SURGERY:

Procedure	Doctor	Hospital/Year
____	___________________	___________________________/______
____	___________________	___________________________/______
____	___________________	___________________________/______

SOCIAL HISTORY:

Tobacco: None ______________ Packs per day:__________________

Alcohol: None_______________Daily:________________ Weekly:__________________

Drug Abuse: ____

Are you now or have you ever been a victim of physical mental abuse? YES NO

Are you or have you ever been in the military?__________________________________

MEDICAL HISTORY: Do you have or ever had any of the following medical conditions? If so, provide details:

Heart disease or high blood pressure

Lung disease (asthma, etc.) ____

Intestinal disorders (colitis, gallbladder disease, etc.) ____

Urinary tract disorders (infections, stones, etc.) ____

Muscular or skeletal problems (arthritis, etc.) ____

Psychiatric or emotional problems____

Endocrine disorders (diabetes thyroid, etc.) ____

Breast disease____

Migraine headaches____

Blood clot disorder____

Other ____

ALLERGIES:

Drug __________________________________ Reaction ________________________

Drug __________________________________ Reaction ________________________

Drug __________________________________ Reaction ________________________

NAME________________________________

CURRENT MEDICATIONS INCLUDING SUPPLEMENTS AND HERBS (include drug, dose and how often taken):

1.____ 5.____

2.____ 6.____

3.____ 7.____

4.____ 8.____

FAMILY HISTORY:

Mother (if alive): Age: _____________ Medical Problem(s) ________________________________

If deceased: Age_____________ Cause of death____

Father (if alive): Age: _____________ Medical Problem(s) ________________________________

If deceased: Age_____________ Cause of death____

Any family history of blood clotting disorder? __________

Any family history of strokes or heart attack before age 50?______________

FAMILY HISTORY OF CANCER (please list relative with type of cancer i.e. mother, sister, aunt, etc.)

Breast ____

Uterine____

Ovarian____

Colon ____

Prostate ____

FOR POST-MENOPAUSAL PATIENTS ONLY:

Age menses ceased: _____________________

Menopausal symptoms:____

____

Have you had a bone density test? ___________ if yes, when?_____________________

Have you had a colonoscopy? _______________ if yes, when?_____________________

REASON FOR TODAY'S VISIT:

____

____

____

____

____

FAMILY DOCTOR: ____

Date of last complete physical:____

NOTES:

Local Pharmacy (name & address)______________________________________

Mail Away Pharmacy (phone & address)__________________________________