

# HISTORY AND PHYSICAL

Name \_\_\_\_\_ Age \_\_\_\_\_

Is there a particular health concern you wish to discuss with the doctor? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of lat Pap Smear \_\_\_\_\_ Was it normal? \_\_\_\_\_  
 If not, please explain any testing \_\_\_\_\_  
 Colposcopy/LEEP/Cryo/Laser \_\_\_\_\_

First day of your last period: \_\_\_\_\_ Was it normal? \_\_\_\_\_ Previous Period: \_\_\_\_\_  
 Age at time of first period: \_\_\_\_\_ How many days between cycles? \_\_\_\_\_ Bleeding how many days? \_\_\_\_\_  
 Any problems or pain with period? \_\_\_\_\_ If so, explain: \_\_\_\_\_

Any medication required? \_\_\_\_\_ Please list: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Current method of birth control: \_\_\_\_\_  
 Past methods of birth control: \_\_\_\_\_ Any problems: \_\_\_\_\_

Do you need to discuss birth control today? \_\_\_\_\_  
 Do you need to discuss safe sex and condom usage? \_\_\_\_\_  
 Any history of sexually transmitted diseases? \_\_\_\_\_

**Pregnancy History:**

How many Full term # \_\_\_\_\_ Premature Birth # \_\_\_\_\_ Abortion: Induced # \_\_\_\_\_ Miscarriage # \_\_\_\_\_

Month/Year	# Weeks Delivery	Labor Duration	Vag or C/S	Sex	Weight	Complications?

**Hospitalization:**

Year	Illness/Surgery	Hospital/Surgeon	Follow-up

Are you receiving any medical treatment at this time? \_\_\_\_\_  
 Please explain: \_\_\_\_\_  
 \_\_\_\_\_

List all medication you are now taking:	Reason	Doctor

Name \_\_\_\_\_

List any drug allergies: \_\_\_\_\_

Medical History	Patient	Family Member	Comment
High Blood Pressure			
Heart Attack/Stroke			
Palpitations			
Chest Pain			
Dizziness			
Eye Problems			
Ear, Nose, Throat Problems			
Headaches/Migraine			
Asthma/Hay Fever			
Breast Disease/Breast Cancer			
Jaundice/Hepatitis			
Bowel Disorders/Cancer			
Urinary Tract Infections			
Blood in Urine			
Anemia/Hereditary Blood Disorders			
Varicose Veins/Phlebitis			
Diabetes			
Thyroid Problems			
Epilepsy/Neurological Disorders			
Cancer Tumor			
Psychological Problems			
Arthritis			

Habits	Amount/Type	Per Day/Per Week
Alcohol		
Smoking		
Drugs		

Do you know how to examine your breasts? \_\_\_\_\_

Do you do the exam? \_\_\_\_\_

Date of last mammography: \_\_\_\_\_

**IF YOU ARE ATTEMPTING TO GET PREGNANT:**

Are you immune to: Rubella (German Measles) \_\_\_\_\_

Rubeola (Measles) \_\_\_\_\_

Varicella (Chicken Pox) \_\_\_\_\_

Do you own a cat and change its litter box? \_\_\_\_\_

Do you eat raw meat? \_\_\_\_\_

Currently taking a multivitamin that includes Folic Acid? \_\_\_\_\_

Aware of genetic screening that is available depending on family background? \_\_\_\_\_

Tay Sachs, Sickle Cell, Thalassernia \_\_\_\_\_

Please state any particular concerns: \_\_\_\_\_

\_\_\_\_\_