Physicians Surgeons for Women

Medical Health History

Patient Name: _______________________________ D.O.B. _________________________________

Name and relationship of person completing form: _______________________________________

Does the patient have a Medical Power of Attorney? _______________

If so, who? ____ Copy attached: ______Yes______No

Personal Medical History (ex: diabetes, cancer, high blood pressure, etc.) Please list below

____

____

____

____

____

____

Pregnancies:

Number of pregnancies: ________________ Number of births: _________________

Contraception:

Currently sexually active? _______ Past sexually active? ________ Contraception: ________________________

Gynecologic History:

Last Period: _____________ Age of 1st menstrual cycle: ________ Date of last exam or Pap? ________________

Any abnormal exams or Paps: _______if so, When: _____________ Where: _______________________________

Surgical History: (List type of surgery, dates and surgeon name)

____

____

____

____

Medications: (List name and dose)

____

____

____

Allergies: (List medicine and the reaction)

____

____

____

Family Medical History (Parents, Grandparents, siblings) Please list below

____

____

____

Social History: Living situation:

____

____

Employment:

____

____

Tobacco (past hx., current hx., amount)

____

____

Alcohol (past hx, current hx, amount, treatment)

____

____

Drugs (past hx, current hx, amount, treatment)

____

____

Exercise:

____

____

Hobbies:

____

Please add any **additional information** you feel is pertinent to the medical care of the above individual:

____

____

____

____

______________________________________ ______________________________________

Signature/Relationship (of person completing form) Date