SEASHORE WOMEN'S HEALTH
PATIENT MEDICAL HISTORY FORM

Name_____ Date of Birth____/____/____ Today's Date_____

Single_____ Married_____ Separated_____ Divorced_____ Widowed_____

How did you hear about us?_____

Medical History Have you ever had any of the following?

- ❑ Anemia
- ❑ High Cholesterol
- ❑ Gall Bladder Disease
- ❑ Pelvic Infections
- ❑ Migraines
- ❑ Asthma
- ❑ Thyroid Problem
- ❑ Heart Disease/Attack
- ❑ Mitral Valve Prolapse
- ❑ Liver Disease/Hepatitis
- ❑ Arthritis
- ❑ Depression/Anxiety
- ❑ Pneumonia
- ❑ Blood Transfusion
- ❑ High Blood Pressure
- ❑ Bleeding Problems
- ❑ Kidney Infections
- ❑ Chicken Pox
- ❑ Drug or Alcohol Problem
- ❑ Tuberculosis
- ❑ Genetic Condition
- ❑ Stroke
- ❑ Blood Clots in Lungs/Legs
- ❑ Bladder Infections
- ❑ Epilepsy/Seizures
- ❑ Diabetes
- ❑ Sickle Cell Disease
- ❑ Cancer

List all medications you are currently taking, including over-the-counter medications, vitamins and herbal remedies:
_____ _____ _____ _____
_____ _____ _____ _____

List any allergies to medications: _____ No Known Allergies

Surgical History Please list all surgeries with dates:
_____ _____
_____ _____

Obstetrical History
Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopics (tubal), and abortions:

Year	M/F	Weight	Type of Delivery	Length of Pregnancy	Problems (e.g., preterm labor, diabetes, high blood pressure)	Name/Age

Gyn History
Age of first period _____
Age of last period _____
Cycle length: every _____days
Lasting_____ day's

Periods are: ❑ Regular ❑ Irregular ❑ Painful ❑ Not really bothersome

Flow is ❑ Light ❑ Light to moderate ❑ Moderate to heavy ❑ Very heavy

Are you sexually active? ❑ Yes ❑ No ❑ virginal

Method of Birth Control:
- ❑ condoms
- ❑ pills
- ❑ other
- ❑ vaginal ring
- ❑ patch
- ❑ none
- ❑ tubal/Essure
- ❑ IUD
- ❑ partner with vasectomy
- ❑ natural family planning

Have you ever had any of the following STDs?
- ❑ Chlamydia
- ❑ Syphilis
- ❑ Hepatitis C
- ❑ Gonorrhea
- ❑ Trichomonas
- ❑ Never had any
- ❑ Herpes
- ❑ HIV
- ❑ HPV
- ❑ Hepatitis B

Have you ever had any of the following?
- ❑ Fibrocystic breasts
- ❑ Ovarian cysts
- ❑ Uterine fibroids
- ❑ Endometriosis

Date of last pap smear_____ normal / abnormal

Have you ever needed any of the following for an abnormal pap?
❑ Colposcopy ❑ Cryosurgery ❑ LEEP/Laser/Conization ❑ No

Date of last mammogram _____ ❑ Normal ❑ Abnormal ❑ Never had one

Date of last bone density _____ ❑ Normal ❑ Osteopenia ❑ Osteoporosis ❑ Never had one

Date of last colonoscopy_____ / Never had one

Family History
Please list any close relatives with a history of the following:

	Relative/Age at Diagnosis		Relative
❑ Breast cancer		❑ High blood pressure	
❑ Ovarian cancer		❑ Diabetes	
❑ Uterine cancer		❑ Heart Disease (heart attack, stroke, bypass surgery)	
❑ Colon cancer			

Social History

Alcohol use	❑ Yes	❑ No	if yes, _____drink(s) per day/week/month			
Tobacco use	❑ Yes	❑ No	if yes, _____ pack(s) per day for _____ years			
Street drug use	❑ Yes	❑ No	Type and frequency_____			
Exercise	❑ Yes	❑ No	Type and frequency_____			
Caffeine	❑ Yes	❑ No	If yes, _____ caffeinated drinks (coffee, tea, soda) per day/week			
Sexual Abuse	❑ Yes	❑ No	if yes, are you safe now?	Yes / No	Counseling?	Yes / No
Physical Abuse	❑ Yes	❑ No	if yes, are you safe now?	Yes / No	Counseling?	Yes / No
Emotional Abuse	❑ Yes	❑ No	if yes, are you safe now?	Yes / No	Counseling?	Yes / No

Review of Systems Do you currently have any of the following?

Y/ N Generally healthy
Y/ N Recent weight gain or loss of 25 lbs.
Y/ N Fever
Y/ N Fatigue
Y/ N Vision problems (excluding glasses)
Y/ N Sinus problems
Y/ N Hearing loss / ringing in ears
Y/ N Headache
Y/ N Chest pain
Y/ N Palpitations
Y/ N Shortness of breath
Y/ N Dizziness
Y/ N Swelling
Y/ N Chronic cough
Y/ N Diarrhea
Y/ N Constipation
Y/ N Bloating
Y/ N Nausea
Y/ N Blood in stools
Y/ N Heartburn/reflux

Y/ N Frequent urination
Y/N Burning with urination
Y/N Incontinence
Y/ N Urgency
Y/ N Bladder infection
Y/ N Stomach pains
Y/ N Vaginal discharge
Y/ N Irregular vaginal bleeding
Y/ N Pelvic pain
Y/ N Painful intercourse
Y/ N Breast lumps
Y/ N Back pain
Y/ N Joint/muscle pain
Y/ N Muscle weakness
Y/ N Depression/anxiety
Y/ N Insomnia

_____ None of the above

Patient Signature_____ Date_____