



# Midwest Center for Women's HealthCare

## Medical History Form

DATE \_\_\_\_\_ NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

OCCUPATION \_\_\_\_\_ Primary Care Physician (name & number) \_\_\_\_\_

WHO REFERRED YOU? \_\_\_\_\_

The following information will assist us in providing you the most excellent care. This information is a confidential record. **Please fill out both sides of this form completely.**

**Have you ever had the following (circle all that apply)**

- |                              |                             |                            |                               |
|------------------------------|-----------------------------|----------------------------|-------------------------------|
| Abnormal MMG                 | DVT/PE                      | High Blood Pressure        | Ovarian Cyst                  |
| Abnormal Pap                 | Endometriosis               | HIV/AIDS                   | Painful Periods               |
| Anemia                       | Epilepsy                    | Irregular Vaginal Bleeding | Problem With Anesthesia       |
| Arthritis                    | Fibroids-Uterus             | Irritable Bowel/Colon      | STD – History of              |
| Asthma/Emphysema             | Frequent Bladder Infections | Kidney Disease             | Stroke                        |
| Blood Transfusion            | Genetic Disorder            | Liver Disorder             | Thyroid - Low (Hypothyroid)   |
| Cancer                       | GERD                        | Lupus                      | Thyroid - High (Hyperthyroid) |
| Clotting Disorder            | Headaches/Migraines         | Mitral Valve Prolapse      | Vaginal Infections            |
| Depression                   | Heart Disease               | Osteopenia                 | Other:                        |
| Diabetes (Type I or Type II) | High Cholesterol            | Osteoporosis               |                               |

Your most recent:	Date	Result	Your most recent:	Date	Result
Mammogram			Cholesterol Check		
PAP smear			Bone Density Scan		
Colonoscopy					

**List all Surgeries and Procedures**

Surgery/Procedure	Year Performed	Surgery/Procedure	Year Performed

**List all prescription and over-the-counter medications and supplements you take regularly**

Medication	Dose	Frequency (how often)	Prescribing Physician (or over the counter)

**List all medication allergies and the reaction you have if you take them**

Allergic To:	Reaction	Allergic To:	Reaction

**Family History** Are You Adopted? **NO YES—if blood relative history unknown, proceed to page 2**

Has any blood relative had any of the following? Indicate "M" for maternal, "P" for paternal family member ( i.e. if your Mother's mother, write MGM)

Problem	Family Member** Please List**	Age Onset	Problem	Family Member	Age Onset
Anemia			Epilepsy		
Asthma			Heart Disease		
Blood Disorder			High Cholesterol		
Cancer – Breast			Hypertension		
Cancer – Colon			Kidney Disease		
Cancer – Ovarian			Migraines		
Cancer – Uterine			Stroke		
Cancer – Other			Thyroid Disorder		
Depression					
Diabetes, Type 1			Other		
Diabetes, Type II					

**Gynecologic History**

Age of first menstruation: \_\_\_\_\_  
 Menopause NO YES, since age \_\_\_\_\_  
 First day of most recent menstrual period: \_\_\_\_\_  
 How many days do your periods last? \_\_\_\_\_  
 How often do you get your period?: \_\_\_\_\_  
 Do you bleed or spot between periods? NO YES  
 Number of sexual partners: in the last year \_\_\_\_\_

Have you ever been pregnant? NO YES  
 How many children have you had? \_\_\_\_\_  
 Are they all living? NO YES  
 Have you ever had a miscarriage? NO YES, how many? \_\_\_\_\_  
 Have you ever had an abortion? NO YES, how many? \_\_\_\_\_  
 Have you ever had an ectopic pregnancy? NO YES, how many? \_\_\_\_\_  
 Do you have any adopted children? NO YES, how many? \_\_\_\_\_

Lifetime \_\_\_\_\_

**Current Birth Control Method** (circle all that apply)

Virgin Natural Family Planning Foam/Gel Patch Tubal Ligation  
 Abstinent Diaphragm Nuvaring Hysterectomy  
 None Withdrawal IUD Depo-Provera No Male Partner  
 Condoms Pill Vasectomy

**Obstetric History**

Date of delivery, miscarriage, abortion	# weeks at delivery	Length of labor	Sex of Baby	Type of delivery? (vaginal or C-section)	Birth Weight	Complications	Location/Doctor

**Social History:**

**Name of Primary Physician:** \_\_\_\_\_

Marital status: Single Engaged Married Divorced Widowed  
 Do you smoke? Never Former—Quit when? Yes—how much per day?  
 Do you drink alcohol? Never Yes—how much and how often?  
 Do you use illegal drugs? Never Yes—what kind, how much and how often?  
 Do you drink caffeine? No Yes—what kind and how often?  
 How much exercise do you get? Sedentary 1-2 times/mo 1-2 times/wk 3-4 times/wk nearly every day daily  
 Do you use seatbelts? NO YES  
 Do you perform monthly breast self exams? NO Always Sometimes Never  
 Have you experienced sexual or physical abuse in the past or present? NO YES  
 Calcium Intake per day? # of Serving per day- \_\_\_\_\_ and/or supplements per day- \_\_\_\_\_ mg

**Please circle any symptoms you are currently having, or have had recently:**

Weight gain	Breast Lumps	Blood in stools	Painful periods	Facial hair growth
Weight loss	Nipple discharge	Fecal incontinence	Irregular periods	Anxiety
Chronic fatigue	Lower leg swelling	Nighttime urination	Vaginal discharge	Depression
Persistent Fever	Varicose veins	Blood in urine	Vaginal odor	Difficulty sleeping
Cough	Diarrhea	Frequent Urination	New skin lesions	Swollen lymph nodes
Shortness of Breath	Constipation	Bladder Discomfort	Changes in moles	Bleed easily
Changes in Vision	Nausea	Leaking urine	Hot flashes	Frequent illnesses
Neck Stiffness	Vomiting	Genital sores	Night sweats	Seasonal allergies
Frequent Headaches	Abdominal Pain	Vaginal discharge	Hair loss	