South Valley Women's Health Care Medical History Form

Name____ DOB___/___/___ Age____ Marital Status__________________

Reproductive History

Total # of Pregnancies ____ # of Full Term Births ____ # of Preterm Births ____ # of Miscarriages ____ # of Living Children____

Last Menstrual Period____/____/____ Age menses began________________

Past Medical History (Circle only those that apply to you and list date of onset)

Obstetric History

Cesarean Section __________ Hypertension __________ Gestational Diabetes__________ Preterm Birth__________

Macrosomia______________ IUGR_________________ Incompetent Cervix ___________ Birth Injury____________

Birth Defect______________ Depression____________ Placenta Previa_______________ Fetal Demise__________

HIV_____________________ Hepatitis______________ Recurrent Miscarriage_________ Anemia______________

Ectopic Pregnancy_________ Group B Strep__________ Placental Abruption___________ Rh negative___________

Molar Pregnancy__________ Toxemia______________ Mastitis____________________

Medical History

Hypertension_____________ Diabetes______________ Depression/Anxiety___________ Asthma________________

Hyperthyroid_____________ Hypothyroid___________ High Cholesterol_____________ Stroke/TIA_____________

Varicose Veins____________ DVT (blood clot)________ Transfusion__________________ Factor V (leiden)________

Bleeding Disorder__________ Clotting Disorder_______ Traumatic Injury______________ Arthritis_______________

Migraines________________ Kidney Disease_________ Recurrent UTI________________ Kidney Stones__________

Kidney Infection___________ Hemorrhoids____________ Cancer (type and onset date)_____________________________

GI Disease________________ Irritable Bowel__________ Peptic Ulcer_________________ Gastritis_______________

Crohn's Disease___________ Rectal Polyps____________ Gallbladder Stones____________ Reflux_________________

Surgical History

Appendix_________________ Gallbladder_____________ Hernia_____________________ Laparoscopy____________

Hysterectomy_____________ Tubal Ligation___________ Endometrial Ablation_________ Removal of Ovary/ies_____

Heart Surgery_____________ Tummy Tuck____________ Breast Augmentation_________

Orthopedic Surgery____

Other____

Gynecologic History

Abnormal Pap_____________ Adenomyosis____________ Endometriosis_______________ STD___________________

Endometrial Polyp__________ Cervical Polyp___________ Fibroid Uterus_______________ Infertility_______________

Genital Herpes_____________ Ovarian Cysts___________ Gynecologic Cancer___________ PMS___________________

Breast Lump_______________ Breast Cancer___________ Fibrocystic Breasts____________ Osteopenia______________

Osteoporosis______________

Family History (Circle those that apply and indicate relationship to you)

Adopted__________________ Genetic Disorder_________ Breast Cancer_______________ Diabetes________________

Hypertension______________ Heart Disease____________ Kidney Disease______________ GI Illness________________

Gynecologic Disease_________ Neurologic Disease________ Respiratory Illness____________ Psychiatric_______________

Cancer____

Social History (Circle those that apply and list details)

Alcohol Use_________________________ Tobacco Use_________________________ Illicit Drugs_______________________

Prescription Drug Abuse______________ Education___________________________ Occupation________________________

Exercise____

Medications (List name and dosage of medications you are currently taking)

_________________________________ ________________________________ _______________________________

_________________________________ ________________________________ _______________________________

List Allergies____