

Name _____ Date _____

Medicines:

Allergies to medicines? _____

If so, to what medicines? _____

Social history:

Occupation: _____

Smoke: _____ If so, how much? _____

Alcohol: _____ If so, how much? _____

Drugs _____

Review of Systems-Place a check if you have had a recent problem in:

	Yes	No		Yes	No
1. Weight loss greater than 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	17. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
2. Bad skin rashes or itching	<input type="checkbox"/>	<input type="checkbox"/>	18. Liver trouble	<input type="checkbox"/>	<input type="checkbox"/>
3. Bad headaches	<input type="checkbox"/>	<input type="checkbox"/>	19. Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
4. Blurred vision or visual problems	<input type="checkbox"/>	<input type="checkbox"/>	20. Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>
5. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	21. Colitis	<input type="checkbox"/>	<input type="checkbox"/>
6. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	22. Excessive diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
7. Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	23. Constant diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
8. Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	24. Bright red blood in stools	<input type="checkbox"/>	<input type="checkbox"/>
9. Heart mur mur	<input type="checkbox"/>	<input type="checkbox"/>	25. Black, tar like stool	<input type="checkbox"/>	<input type="checkbox"/>
10. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	26. Bladder infections	<input type="checkbox"/>	<input type="checkbox"/>
11. Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	27. Kidney infection	<input type="checkbox"/>	<input type="checkbox"/>
12. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	28. Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
13. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	29. Stop bleeding when cut	<input type="checkbox"/>	<input type="checkbox"/>
14. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	30. Blood clot in legs or lungs	<input type="checkbox"/>	<input type="checkbox"/>
15. Gall bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	31. Depression or mental illness	<input type="checkbox"/>	<input type="checkbox"/>
16. Breast lumps or pain	<input type="checkbox"/>	<input type="checkbox"/>			

Past Surgery

Past Medical History

Obstetric history (include all pregnancies starting for first)

1. _____
 2. _____
 3. _____
 4. _____

Do you have any reason to believe you could have HIV?
 Have you ever been hurt (physically or mentally) by your partner? _____

Gynecological History

1. Age of first menstrual period _____
 2. Length of period (in days) _____
 3. Cramps: Mild Moderate Severe
 4. Interval (from first day of one period to the first day of the next period) _____
 5. Date of last pap smear _____
 Abnormal pap ever? _____
 6. Have you ever had chlamydia? _____
 gonorrhea? _____
 7. Have you ever had a mammogram? _____

Genetic History

Name _____

Date _____

Are any of your blood relatives:

Your partner's family (if desiring fertility):

	Yes	No	Yes	No
English, Irish:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mediterranean: (Greek, Italian)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ashkenazi:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
French Canadian:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
African Descent:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does anyone in your family have:

Your partner's family:

Mental retardation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Down syndrome:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open spine defects (Spina bifida, Anencephaly)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic fibrosis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle cell anemia:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thalassemia:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth defects:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Male information: Medical Problems _____
 Allergies _____
 Occupation _____

Medications _____
 Alcohol _____ Smoking _____ Drugs _____
 Previous evaluation _____

Please do not write below this line.

