

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:

- | | |
|--|--|
| 1. Weight loss greater than 10 pounds _____
2. Bad skin rashes or itching _____
3. Bad headaches _____
4. Blurred vision or visual problems _____
5. Diabetes _____
6. High blood pressure _____
7. Heart trouble _____
8. Rheumatic fever _____
9. Heart murmur _____
10. Chest pain _____
11. Palpitations _____
12. Asthma _____
13. Shortness of breath _____
14. Tuberculosis _____
15. Gall bladder problems _____
16. Breast lumps or pain _____ | 17. Hepatitis _____
18. Liver trouble _____
19. Ulcers _____
20. Stomach pain _____
21. Colitis _____
22. Excessive diarrhea _____
23. Constant constipation _____
24. Bright red blood in stools _____
25. Black, tar-like stools _____
26. Bladder infections _____
27. Kidney infection _____
28. Kidney stones _____
29. Stop bleeding when cut _____
30. Blood clot in legs or lungs _____
31. Depression or mental illness _____ |
|--|--|

Past Surgery

Past Medical History

Obstetric History (include all pregnancies starting from 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? _____

Gynecologic 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 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? _____
8. Have you had a bone mineral density? _____

Name _____ Date _____

Genetic History

Are any of your blood relatives:

English, Irish: Yes ___ No ___
 Mediterranean: Yes ___ No ___
 (Greek, Italian)
 Ashkenazi Jewish: Yes ___ No ___
 French Canadian: Yes ___ No ___
 African Descent: Yes ___ No ___

Your partner's family (if desiring fertility):

Yes ___ No ___
 Yes ___ No ___
 Yes ___ No ___
 Yes ___ No ___
 Yes ___ No ___

Does anyone in your family have:

Mental retardation: Yes ___ No ___
 Down syndrome: Yes ___ No ___
 Open spine defects (spina bifida,
 anencephaly) Yes ___ No ___
 Cystic fibrosis: Yes ___ No ___
 Sickle cell anemia: Yes ___ No ___
 Thalassemia: Yes ___ No ___
 Cancer: Yes ___ No ___
 Birth defects: Yes ___ No ___
 Diabetes: Yes ___ No ___
 Heart Disease Yes ___ No ___
 Stroke: Yes ___ No ___

Your partner's family

Yes ___ No ___
 Yes ___ No ___
 Yes ___ No ___
 Yes ___ No ___
 Yes ___ No ___
 Yes ___ No ___
 Yes ___ No ___
 Yes ___ No ___
 Yes ___ No ___
 Yes ___ No ___

Male Information: Medical Problems _____
 Allergies _____
 Occupation _____

Medications _____
 Alcohol _____ Smoking _____ Drugs _____
 Previous Evaluation _____

Please do not write below this line.

