Creekside Center for Women

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PATIENT NAME: _____ BIRTH DATE:_____

MEDICAL HISTORY

GYNECOLOGICAL HISTORY

Have you gone through menopause: _____ If so, when? _____

Have you had a hysterectomy? _____ If so, when? _____

When did you start your last menstrual period? _____

How long do your periods normally last? _____ Days How many days in between your periods? _____ Days

Are your periods regular? _____ When was your last pap smear? _____

Have you ever had a mammogram? _____ If yes, when? _____

Contraception: Current _____ Past _____

Have you had any unusual weight loss or gain in the last year? _____ _____ lbs gain/loss

Have you had any change in appetite during the last year? _____

HABITS: Smoking _____ cig/day/yrs Alcohol _____ oz/wk Coffee _____cup/day

Do you now or have you ever used street drugs? _____

OBSTETRICAL HISTORY

List all pregnancies below.

Date of Birth	Hours of Labor	Weight of Baby	Sex	C-Section?

HOSPITALIZATIONS AND SURGERIES

Please list below.

Month and Year of Admission	Illness/Operation

PAST MEDICAL AND FAMILY HISTORY

Have you or any family member had any of the following?

	You	Family		You	Family		You	Family
Headaches/Migraine	_____	_____	Bowel Disorders	_____	_____	Skin Disease	_____	_____
Heart Disease	_____	_____	Kidney Disease	_____	_____	Diabetes	_____	_____
Hypertension	_____	_____	Urinary Incontinence	_____	_____	Night Sweats	_____	_____
Respiratory Disease	_____	_____	Urinary Infections	_____	_____	Thyroid Disease	_____	_____
Breast Disease	_____	_____	Anemia/Blood Disorder	_____	_____	Cancer	_____	_____
Jaundice/Hepatitis	_____	_____	Blood Transfusions	_____	_____	Epilepsy/Neurol Disorder	_____	_____
Gallbladder Disease	_____	_____	Varicose Veins/Phlebitis	_____	_____	Arthritis	_____	_____
H. Hernia/Peptic Ulcer	_____	_____						

MEDICATIONS

ALLERGIES

List all current medications and the dosage you are now taking.	Are you allergic to any medication?
_____	_____
_____	_____
_____	_____
_____	_____
Drugstore: Phone:	_____

Reason for today's visit: _____

_____