PERSONAL MEDICAL HISTORY

The following information is an essential part of addressing your health concerns
Please take the time to fill this out completely.

Name: _____ Date: _____ Occupation: _____
Date of Birth: _____ Age: _____ Referred By: _____

MAIN COMPLAINT/REASON FOR EXAM

PREGNANCY HISTORY	
Number of Pregnancies	
Children Born Alive	
Living Children	
Stillborn	
Miscarriages	
Tubal Pregnancies	
Abortion	
Vaginal Deliveries	
Cesareans	
VBAC's (vaginal births after cesarean)	

MENSTRUAL HISTORY
Age periods began?
Age periods stopped?
How often do they occur?
First Day of Last Menstrual Period?
Number of days of flow?
Amount of flow? ☐ Heavy ☐ Moderate ☐ Light
Spotting between periods? ☐ Yes ☐ No
Severe cramps with your period? ☐ Yes ☐ No
Severe cramps between periods? ☐ Yes ☐ No

PAP SMEAR HISTORY
Last pap smear?
Was it normal? ☐ Yes ☐ No
Have you ever had an abnormal pap smear? ☐ Yes ☐ No
If yes, when?
Did it require treatment? ☐ Yes ☐ No
How was it treated? ☐ Laser ☐ Freezing ☐ Burning ☐ Pills ☐ Cream ☐ Cone Biopsy

BLEEDING DISORDER	
☐	Anemia
☐	Blood Clots
☐	Hemophilia
☐	Phlebitis
☐	Sickle Cell
☐	Thalassemia
☐	Transfusion
☐	Varicose Veins
Other:	
Blood Type:	

BREAST PROBLEMS	
☐	Breast Biopsy
When? ☐ Left ☐ Right	
☐	Breast Cancer
☐	Breast Mass
☐	Fibrocystic Breasts
☐	Nipple Discharge
Last Mammogram	
Other:	

CANCER	
☐	Breast
☐	Cervical
☐	Colon
☐	Lung
☐	Ovarian
☐	Skin
☐	Uterine
☐	Vulvar
Other:	

CARDIOVASCULAR	
☐	Rheumatic Fever
☐	Heart Attack
☐	Heart Failure
☐	Heart Murmur
☐	Heart Palpitations
☐	High Blood Pressure
☐	High Cholesterol
☐	Mitral Valve Prolapse
☐	Stroke
Other:	

ENDOCRINE	
☐	Abnormal Hair Growth
☐	Diabetes
☐	Hypoglycemia
☐	Osteoporosis
☐	Thyroid Disease
Other:	

GASTROINTESTINAL	
☐	Colitis
☐	Constipation
☐	Diarrhea
☐	Gallbladder Disease
☐	Hepatitis/Jaundice
☐	Irritable Bowel Syndrome
☐	Liver Disease
☐	Ulcers
Other:	

PULMONARY	
☐	Asthma
☐	Bronchitis
☐	Emphysema
☐	Pneumonia
☐	Tuberculosis
Other:	

GYNECOLOGY	
☐	AIDS
☐	Chlamydia
☐	Endometriosis
☐	Frequent Vaginal Infections
☐	Gonorrhea
☐	Herpes
☐	Ovarian Cysts
☐	Painful Intercourse
☐	Pelvic Inflammatory Disease
☐	Polycystic Ovaries
☐	Syphilis
☐	Uterine Fibroids
☐	Vaginal Burning
☐	Vaginal Discharge
☐	Vaginal Itching
☐	Vaginal Odor
☐	Warts/Condyloma
Other:	

Great Plains Women's Health Center, PC 1700 11th St. W
Williston, ND 58801
(701) 774-7687

Caring for Women in All Stages of Life

PERSONAL MEDICAL HISTORY

NEUROLOGICAL	PSYCHOLOGICAL	URINARY	SURGICAL HISTORY
☐ Epilepsy	☐ Alcohol/Drug Addiction	☐ Bladder Infections	☐ Appendix
☐ Migraine Headaches	☐ Anorexia	☐ Blood in Urine	☐ Bladder Suspension
☐ Multiple Sclerosis	☐ Attempted Suicide	☐ Burning with Urination	☐ Breast Biopsy
☐ Palsy	☐ Bulimia	☐ Kidney Infections	☐ Cesarean Section
☐ Seizures	☐ Depression	☐ Kidney Stones	☐ Dilation & Curettage (D&C)
Other:	☐ Manic Depressive	☐ Loss of urine when laughing, coughing or sneezing?	☐ Gallbladder
	☐ Marital Problems		☐ Hemorrhoid
	☐ Sexual Abuse		☐ Umbilical Hernia
	Other:	☐ Frequently don't make it to the restroom in time.	☐ Hernia (other)

Hysterectomy
Vaginal
Abdominal
LAVH

☐ Laparoscopy
Why?

☐ Laser of Cervix

Ovary Removal
Left Right Both

☐ Tonsillectomy

☐ Tubal Ligation

Other:

FAMILY HISTORY

M-Mother F=Father B=Brother S=Sister MM=Mother's Mother FF=Father's Father MS=Mother's Sister, etc.

CONDITION	FAMILY	COMMENTS
example: Breast Cancer	M, MM	MM died at age 70
☐ Breast Cancer		
☐ Uterine Cancer		
☐ Ovarian Cancer		
☐ Colon Cancer		
☐ DES Exposure		
☐ Bleeding Disorder		
☐ Endometriosis		
☐ Diabetes		
☐ Heart Disease		
☐ High Blood Pressure		
☐ Tuberculosis		
☐ Kidney Disease		
☐ Psychiatric Disorder		
☐ Emotional Problems		
☐ Genetic Disorder		
☐ Neurological Disease		
☐ Thyroid Disease		
☐ Hepatitis/Jaundice		
☐ Varicose Veins/Phlebitis		
☐ High Cholesterol		
☐ Osteoporosis		

COMMENTS

SOCIAL HISTORY

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated

Sexually Active
Yes No Never
Age began Sexual Activity:

Birth Control Method:
- ☐ Abstinence
- ☐ Condoms
- ☐ Depo Provera
  - Last Injection:
- ☐ Diaphragm
- ☐ Essure
- ☐ Foam
- ☐ Hormonal Implant
- ☐ IUD
- ☐ Natural Family Planning
- ☐ Pill
  - Brand:
- ☐ Sponge
- ☐ Tubal Ligation
- ☐ Vasectomy

Do you use TOBACCO?
Yes No
How much?
How Long?
Have you ever smoked?
Yes No Stopped

Do you drink ALCOHOL?
Yes No
How much per week?

Do you use "STREET DRUGS"
(crack, pot, LSD, speed, downers)
Yes No
Have you ever?
Yes No
When?

MEDICATIONS
(Prescription & non prescription with dose)

ALLERGIES
(List the allergy and its effect)