MEDICAL HISTORY

Initial Review:

Subs. Reviews:

Tennessee Valley OB-Gyn Clinic, PC
910 Adams St., Suite 200
Huntsville, AL 35801

Subs. Reviews:

Patient Name ______________________ Birthdate ______________ Today's Date ______________

Date of last PAP smear ______________ Date of last MAMMOGRAM __________ Today's Problem: __________

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GYNECOLOGICAL HISTORY:

Date of first day of last menstrual period: ______________________ Menstrual cycle length (days): __________

Interval (# of days) between two cycles: __________ Number of pads or tampons used on heaviest days: __________

Do you douche? ☐ Yes ☐ No If yes, how often? ______________

Do you ever have bleeding or spotting after sexual intercourse?

Do you spot before your period? ☐ Yes ☐ No If yes, what color is it? ______________________

Do you ever have bleeding or spotting between period: ☐ Yes ☐ No

Have you ever

Had an illness that required medication?	☐ Yes	☐ No
Had female cancer?	☐ Yes	☐ No
Had an abnormal PAP smear?	☐ Yes	☐ No
Been treated for vaginitis?	☐ Yes	☐ No
Been treated for itching?	☐ Yes	☐ No
Been treated for discharge?	☐ Yes	☐ No
Been treated for any sexually transmitted diseases (STD)	☐ Yes	☐ No
Taken birth control pills?	☐ Yes	☐ No
Had an IUD?	☐ Yes	☐ No
Had an infection in the fallopian tubes?	☐ Yes	☐ No
Had genital herpes?	☐ Yes	☐ No

FOOD / DRUG ALLERGIES

OBSTETRICAL HISTORY:

How many pregnancies have you had? ______________

How many miscarriages? ______________

How many abortions? ______________

CURRENT MEDICATIONS

List all pregnancies:

	Year	Baby's weight	Vaginal or C-section	Sex	Complications
1)					
2)					
3)					
4)					
5)					
6)					

(Over for additional info)

Health Habits		
Check ( ) which substances you use and quantity:		
	Caffeine	
	Tobacco	
	Alcohol	
	Drugs	

Hospitalizations / Surgeries		
Year	Hospital	Reason / Surgery
1)		
2)		
3)		
4)		

Review of Systems / Personal Medical History (circle any that apply)

AIDS	Chest pain	Heart murmur	Polio
Alcoholism	Chicken Pox	Hemorrhoids	Psychiatric disorder
Allergies	Chronic cough	Hepatitis	Rectal bleeding
Anemia	Circulation problems	Hernia	Rheumatic fever
Anorexia	Constipation	High Blood Pressure	Scarlet fever
Appendicitis	Diabetes	High Cholesterol	Shortness of Breath
Arthritis	Diarrhea	HIV positive	Sleep disturbance
Asthma	Dizziness	Kidney Disease	Sore that won't heal
Bleeding Disorder	Emphysema	Kidney Stones	Stroke
Blood Clots	Epilepsy/Seizures	Liver Disease	Suicide attempt
Blood in sputum	Fainting	Loss of Appetitie	Sweats
Blood in Urine	Fatigue	Mononucleosis	Thyroid problems
Breast lump	Forgetfulness	Multiple Sclerosis	Tonsillitis
Bronchitis	Frequent Urination	Mumps	Tuberculosis
Bruise easily	Gall Bladder Disease	Muscle pain	Typhoid fever
Bulimia	Glaucoma	Nausea	Ulcers
Burning Urination	Goiter	Pacemaker	Urgent Urination
Cancer	Gout	Palpitations	Visual disturbance
Cataracts	Headaches	Phlebitis	Vomiting
Chemical Dependency	Heart Disease	Pneumonia	Vomiting Blood

FAMILY HISTORY

Give the relationship of any blood relative who has had:

Arthritis	Congential Heart Defect	Insanity	Ovarian Cancer
Asthma	Diabetes	Kidney Disease	Rheumatic Heart
Birth Defect	Epilepsy / Seizures	Leukemia	Stomach Ulcers
Bleeding	Goiter	Migraine headaches	Stroke
Breast Cancer	Heart Attack	Nervous Breakdown	Suicide
Colitis	High Blood Pressure	Other Cancer	Uterine Cancer

I certify that the information provided here is correct to the best of my knowledge. I will not hold my physician or any members of her staff responsible for any errors or omissions that I may have made in completing this form.

Patient Signature: ______________________________ Date: ______________