

PAUL A. MIKEL MD LINDA I. SODOMA DO
MEDICAL HISTORY FORM

NAME _____ BIRTHDATE _____

DATE _____ SSN _____

I. What brings you to see the doctor? _____

II. **Menstrual History:** Age when 1st period started _____
 Are your cycles regular? **Yes No** Are your periods: **Regular Irregular**
 How many days do you bleed? _____ How long are your cycles (average is 28-30 days) _____
 How many days of heavy flow? _____ Do you need double protection? **Yes No**
 Do you have bleeding between periods? **Yes No** Are your periods painful? **Yes No**
 How many days of pain per cycle? _____

III. **Obstetric History** Number of: Pregnancies _____ Miscarriages _____
 Elective Terminations _____ Living Children _____

YEAR	MONTHS PREGNANT	COMPLICATIONS	BIRTH WEIGHT	SEX	COMMENTS

IV. **Gynecologic History:**
 Date of last pap smear (mo/yr) _____ Have you ever had an abnormal pap? **Yes No**
 Have you ever had an infection of your uterus, tubes or ovaries (PID) **Yes No**
 Prior Gynecological Surgeries _____

Have you ever had Chlamydia, gonorrhea, herpes, genital warts or any other sexually transmitted disease? **Yes No** Do you have frequent vaginal infections/abnormal discharge? **Yes No**
 Do you have pain/bleeding with intercourse? **Yes No**
 Do you have more than one sexual partner? **Yes No**
 When was your last mammogram? _____ Was it normal? _____
 Any other significant past gynecological history? _____

V. **Contraception:** Current Method (circle)
 None Condoms Tubal Ligation Pills IUD Foam Norplant
 Inserts Rhythm Vasectomy Diaphragm Withdrawal

VI. **Family History**

Relationship	Age or Age at Death	Illnesses or Cause of Death
Mother		
Father		
Sister(s)		
Brother(s)		

Any family history of (circle all that apply) **Diabetes Heart Disease High Cholesterol Alzheimer's**
Strokes Breast Cancer Uterine Cancer Ovarian Cancer Other Cancers Osteoporosis

VII. General Medical History

Do you have any ongoing medical problems? _____

Prior Non-gynecological surgeries? _____

List current medications: _____

List vitamins and herbal supplements including doses _____

Allergies to medications _____

List childhood illnesses _____

Has your weight changed in the last year? Yes No If so, how much? _____

Do you have problems with the following?

Head, eyes, ears, nose & throat (i.e. convulsions, visual difficulties, seizures, etc)	YES	NO
Breathing (i.e. cough, asthma, TB, valley fever)	YES	NO
Hypertension	YES	NO
Diabetes	YES	NO
Heart Disease (heart attack, palpitations, chest pain, murmur)	YES	NO
Breast Discharge (milky, watery, bloody), Pain or Breast Lumps	YES	NO
Nausea, Vomiting, Diarrhea, Blood in Stool, Hepatitis	YES	NO
Kidney or Bladder Infection, Stones, Blood in Urine	YES	NO
Skin Problems (including excessive hair, hair loss, acne)	YES	NO
Emotional Problem (Depression, suicide attempts, anxiety)	YES	NO

Please explain any Yes answer _____

VIII. Social History

Do you smoke? **Yes No** If so, how long have you smoked? _____ Years Cigarettes/Day _____

Did you smoke previously? _____ Years When did you quit? _____

Do you drink alcohol? **Yes No** What and how much? _____

Do you use street drugs? **Yes No** Identify drugs _____

Do you exercise? **Yes No** What type and how often? _____

Do you eat a balanced diet? **Yes No** Occupation _____