Associates in
Women's Health
of the Mahoning Valley, Inc.

Obstetrics
Gynecology
Infertility

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MEDICAL HISTORY

Name: (last) _____ (first) _____ Age: _____ Marital Status: M D S W

Occupation: _____ Height: ____ ft ____ in Weight _____ lbs.

Reason for seeing doctor: _____

_____

_____

Referred by: _____

PERSONAL MEDICAL HISTORY

Do you have a history of any of the following:

Frequent Headaches	❍ Yes	❍ No	Stomach, Bowel or Gallbladder Problems	❍ Yes	❍ No
Neurologic Disorders	❍ Yes	❍ No	Bladder or Kidney Problems	❍ Yes	❍ No
High Blood Pressure	❍ Yes	❍ No	Asthma, Tuberculosis or Lung Disease	❍ Yes	❍ No
Diabetes	❍ Yes	❍ No	Heart Disease or Rheumatic Fever	❍ Yes	❍ No
Cancer	❍ Yes	❍ No	Psychiatric Disorders	❍ Yes	❍ No
Breast Disease	❍ Yes	❍ No	Arthritis or Auto-Immune Disorders	❍ Yes	❍ No
Thyroid Problems	❍ Yes	❍ No	Jaundice, Hepatitis or Liver Disease	❍ Yes	❍ No

Please explain any of the above: _____

_____

_____

Please list any medications you are currently taking: _____

_____

_____

Are you allergic to any medications? _____

Please list any surgeries you have had: _____

_____

_____

MEDICAL HISTORY

Please list any other hospitalizations, the dates and the reasons: _____

_____

_____

Please list any blood transfusions and the dates: _____

FAMILY HEALTH HISTORY

Please list the current age (or age at death) and any health problems of the following members of your family:

Father: _____ Deceased? ❍ Yes ❍ No Date: _____

Mother: _____ Deceased? ❍ Yes ❍ No Date: _____

Children: _____

_____

Siblings: _____

_____

Please check any of the following that are found in your family:

❍ High Blood Pressure ❍ Diabetes ❍ Cancer ❍ Heart Disease ❍ Stroke ❍ Kidney Disease ❍ Breast Disease
❍ Thyroid Disease

PREGNANCY HISTORY

How many times have you been pregnant? _____ Number of living children: _____

Elective Terminations/Abortions: _____ Miscarriages: _____

Twin pregnancy or multiple gestation: _____ Ectopic or Molar Pregnancies: _____

GYNECOLOGICAL HISTORY

Age when menstrual cycles began? _____ yrs

First day of last menstrual period, or if no longer menstruating, date when periods ceased? _____

Are your cycles regular? ❍ Yes ❍ No Number of days between periods: _____ Length of periods: _____

Do you have premenstrual symptoms? ❍ Yes ❍ No Medications used: _____

Do you have pain with your periods? ❍ Yes ❍ No Medications used: _____

Are you sexually active? ❍ Yes ❍ No Current method of contraception: _____

Past methods of contraception: _____

Date of last Pap smear: _____ Last Mammogram: _____

Results: _____

Do you perform regular breast self-examinations? ❍ Yes ❍ No

Have you ever used hormone replacement medication or oral contraceptives? ❍ Yes ❍ No

If so, what type? _____

MEDICAL HISTORY

Do you now or have you ever had any of the following: ❍ Yes ❍ No

Recurrent vaginal infections	❍ Yes ❍ No	Ovarian cyst or tumor	❍ Yes ❍ No
Vaginal discharge, itching or odor	❍ Yes ❍ No	Abnormal bleeding	❍ Yes ❍ No
Pelvic infection or PID	❍ Yes ❍ No	Fibroids or uterine tumor	❍ Yes ❍ No
Herpes	❍ Yes ❍ No	DES exposure	❍ Yes ❍ No
Genital Warts	❍ Yes ❍ No	Arthritis or auto-immune disorders	❍ Yes ❍ No
Endometriosis	❍ Yes ❍ No	Loss of urine involuntarily, or with coughing, sneezing or activity	❍ Yes ❍ No
Gonorrhea, Chlamydia or other sexually transmitted diseases	❍ Yes ❍ No		

Are there any sexually related problems you would like to discuss? ❍ Yes ❍ No

GENERAL HEALTH

Do you consider yourself: ❍ Heterosexual ❍ Bisexual ❍ Homosexual

Have you ever experienced sexual or physical abuse? ❍ Yes ❍ No

The following are considered risk factors for HIV infection. Please check any which may apply to you since 1979:

User of IV drugs or sexual partner who uses IV drugs	❍ Yes ❍ No
Sexual partner who is HIV-positive or has AIDS	❍ Yes ❍ No
Sexual contact with a gay or bisexual man	❍ Yes ❍ No
Artificial insemination by donor	❍ Yes ❍ No
Sexual partner from an area where AIDS is common	❍ Yes ❍ No
Do you want a screening test for HIV infection?	❍ Yes ❍ No

How many cigarettes do you smoke each day? _____ How many years smoking? _____

Past smoking history: _____ Would you like information on quitting ❍ Yes ❍ No

How many alcohol containing drinks do you consume each week? _____

Have you or any members of your family been treated for alcoholism? ❍ Yes ❍ No

How often do you use drugs like marijuana, cocaine, amphetamines or other recreational drugs? _____

Have you ever been treated for drug addiction? ❍ Yes ❍ No

Signature: _____ Date: _____