

Name:

Birthdate:

Reason For Visit:

Menstruated First Time at the Age of:

At First Periods Were:  Regular  Irregular Last Menstrual Period Started on mm/dd/yyyy:

Was it Normal?  Yes

Previous Menstrual Period mm/dd/yyyy:

What is Your Normal Weight? lbs. Weight Gain or Loss in the Last Six Months:  Yes  No

### Menstrual History

Up to This Time Periods Have Been?  Somewhat Regular  Irregular  Regular

If Periods Have Been Regular, the Interval Between Periods is Days:

If Irregular, the Interval Between Periods Ranges From Days: To Days:

Menstral Flow Usually is:  Scant  Moderate  Heavy  Excessive

Do You Usually Have Clots With Your Periods?  Yes  No Are Your Periods Usually Painful?  Yes  No

If Painful, Describe:  Mild  Moderate  Severe  Incapacitating

Any Other Symptoms Associated With Your Periods?  Yes  No

Do You Ever Have Bleeding or Spotting Between Periods?  Yes  No

Do You Ever Have Pain With Sexual Intercourse?  Yes  No

Do You Ever Have Vaginal Discharge?  Yes  No

Have You Ever Had a Cancer Smear (Pap Smear) Made?  Yes  No

If Yes, Was it Normal?     Yes     No    Date mm/dd/yyyy:

Have You Ever Missed Periods Without Being Pregnant?     Yes     No

Are You Taking Any Medications?     Yes     No    If So, Which Ones:

Are You Allergic to Any Drugs?     Yes     No    If So, Which Ones:

Are Your Immunizations Up to Date?     Yes     No    How Many Pregnancies?

Have You had a Miscarriage?     Yes     No    An Abortion?     Yes     No

How Many Living Children?

**Pregnancies: Please Provide Information Concerning Any Previous Pregnancies**

Number:

Year of Birth:

Length in Inches:

Sex:

Birth Weight:

Complications:

Miscarriage or Abortions:



**Past Illnesses: Check Each of the Following Diseases That You Have Ever Had. Also Indicate Year, if Known**

Measles	Year	Epilepsy	Year
Mumps	Year	Mental Disease	Year
Chicken Pox	Year	Venereal Disease	Year
German Measles	Year	Diabetes	Year
Poliomyelitis	Year	Thyroid Disease	Year
Rheumatic Fever	Year	Operation or Injuries	Year
Scarlet Fever	Year	Blood Transfusion	Year
Tuberculosis	Year	High Blood Pressure	Year
Blood Disease	Year	Varicose Veins	Year
Heart Disease	Year	Phlebitis	Year
Kidney Disease	Year	Allergies	Year

**Have You Ever Had an Operation On Any of the Following?**

Appendix	Year	Hernia	Year
Gallbladder	Year	Tonsils	Year
Kidney Stones	Year	Hemorrhoids	Year
Varicose Veins	Year	Tumors	Year

**Have You Ever Had an Operation On Any of the Following? (Cont.)**

<b>Chest</b>	<b>Year</b>	<b>Vagina Repair</b>	<b>Year</b>
<b>Spine</b>	<b>Year</b>	<b>Caesarean Section</b>	<b>Year</b>
<b>Breast</b>	<b>Year</b>	<b>D&amp;C</b>	<b>Year</b>
<b>Ovary</b>	<b>Year</b>	<b>Freezing of Cervix</b>	<b>Year</b>
<b>Womb</b>	<b>Year</b>	<b>Cautery of Cervix</b>	<b>Year</b>
<b>Tubes</b>	<b>Year</b>	<b>Conization of Cervix</b>	<b>Year</b>

**As of Now Do You Have Any of the Following Symptoms?**

- |  |                                      |                             |
|--|--------------------------------------|-----------------------------|
| <b>Chills or Fever</b>                       | <b>Recent Weight Change</b>          | <b>Headaches</b>            |
| <b>Night Sweats</b>                          | <b>Excessive Weakness</b>            | <b>Fainting Spells</b>      |
| <b>Dizziness</b>                             | <b>Marked Tiredness</b>              | <b> ringing In Ears</b>     |
| <b>Excessive Sweating</b>                    | <b>Unusual Hair Growth</b>           | <b>Glasses</b>              |
| <b>Poor Appetite</b>                         | <b>Abnormal Distribution of Hair</b> | <b>Hoarseness</b>           |
| <b>Nosebleeds</b>                            | <b>Toothache</b>                     | <b>Shortness Of Breath</b>  |
| <b>Marked Disturbance of Vision</b>          | <b>Eye Pain</b>                      | <b>Lumps In The Breasts</b> |
| <b>Soreness In Mouth, On Gums, Or Tongue</b> | <b>Difficulty Swallowing</b>         | <b>Dentures</b>             |
| <b>Swelling Neck, Under Arms Or In Groin</b> | <b>Cough</b>                         |                             |

**As of Now Do You Have Any of the Following Symptoms? (Cont.)**

- |                               |  |   |
|-------------------------------|--|---|
| <b>Nausea And Vomiting</b>    | <b>Pus In Urine</b>                            | <b>Sudden Urgent Need To Urinate</b>    |
| <b>Blood In Stool</b>         | <b>Sugar In Urine</b>                          | <b>Swelling Of Feet, Hands Or Face</b>  |
| <b>Tarry Stool</b>            | <b>Leg Cramps With Walking</b>                 | <b>Frequency Of Nighttime Urination</b> |
| <b>Change In Bowel Habits</b> | <b>Chest Pain</b>                              | <b>Depression</b>                       |
| <b>Painful Urination</b>      | <b>Nervousness</b>                             | <b>Other Complaints</b>                 |
| <b>Blood In Urine</b>         | <b>Painful Feet</b>                            | <b>Excessive Worry</b>                  |
| <b>Nightmares</b>             | <b>Loss Of Urine With Coughing Or Sneezing</b> |   |

**Have Any Of Your Grandparents, Parents, Brothers, Sisters, Uncles, Aunts, Or Children Ever Been Treated For**

- |                            |            |  |            |
|----------------------------|------------|--|------------|
| <b>Cancer</b>              | <b>Who</b> | <b>Muscular Disorders</b>              | <b>Who</b> |
| <b>Diabetes</b>            | <b>Who</b> | <b>Blood Disease</b>                   | <b>Who</b> |
| <b>Tuberculosis</b>        | <b>Who</b> | <b>Epilepsy</b>                        | <b>Who</b> |
| <b>Kidney Disease</b>      | <b>Who</b> | <b>Severe Deafness</b>                 | <b>Who</b> |
| <b>Asthma</b>              | <b>Who</b> | <b>Nervous Disorders</b>               | <b>Who</b> |
| <b>Glaucoma</b>            | <b>Who</b> | <b>Family History Of Birth Defects</b> | <b>Who</b> |
| <b>Heart Disease</b>       | <b>Who</b> | <b>History Of Twins</b>                | <b>Who</b> |
| <b>High Blood Pressure</b> | <b>Who</b> | <b>Nervous Breakdown</b>               | <b>Who</b> |

**Have Any Of Your Grandparents, Parents, Brothers, Sisters, Uncles, Aunts, Or Children Ever Been Treated For (Cont.)**

<b>Parents Living</b>	<b>Number Living</b>
<b>Sisters</b>	<b>Number Living</b>
<b>Brothers</b>	<b>Number Living</b>

**Social / Marital History: Check Yes or No Fill in the Blanks Where Appropriate**

<b>Single</b>	<b>Number Of Years Married</b>		
<b>Married</b>	<b>Married More Than Once?</b>	<input type="radio"/> <b>Yes</b>	<input type="radio"/> <b>No</b>
<b>Divorced</b>	<b>If Yes, How Many Times?</b>		
<b>Separated</b>	<b>Husband Age</b>	<b>Height</b>	<b>Weight</b>
<b>Widowed</b>	<b>Health</b>		

**Check Birth Control Method Used**

<b>Diaphragm</b>	<b>Vasectomy</b>	<b>Withdrawal</b>
<b>Condom</b>	<b>Foam</b>	<b>None</b>
<b>IUD</b>	<b>Rhythm</b>	<b>Other</b>
<b>Pills</b>	<b>Tubal Ligation</b>	

**Do You Habitually Use Laxatives?**       Yes       No

**Do You Use Alcohol?**       Yes       No      **How Much?**      **How Long?**      **Number Of Years**

**Do You Use Tobacco?**       Yes       No      **How Much?**      **How Long?**      **Number Of Years**

**Have You Ever Claimed Industrial Compensation?**       Yes       No

**Have You Ever Lived In a Foreign Country?**       Yes       No

**Do You Use Narcotics?**       Yes       No

