OB/GYNE
Associates of Lake Forest, Ltd.

Patient Medical History Form

Name:	Date:

NAME OF CHILD	DATE OF DELIVERY MM/DD/YY YY	HOW MANY WEEKS AT DELIVERY	C-SEC OR VAG	M/F & WEIGHT	TYPE OF ANESTHESIA	HOSPITAL	COMPLICATIONS
#1							
#2							
#3							
#4							
#5							
#6							

History of miscarriages? ☐ Yes ☐ No **# of miscarriages** _____ **Was a D&C required? (If yes) Date:** _____
History of abortions? ☐ Yes ☐ No **# of abortions** _____

GYNECOLOGICAL HISTORY
Age of first period?
How often do you get your period? (i.e. every 2 weeks, every month?)
How many days does your period last?
How many pads and/or tampons do you use on an average day?
Cramps/pain? What medications do you use?
Contraceptive method currently being used? ☐ Patch ☐ Vasectomy ☐ Ring ☐ Depo ☐ Condoms ☐ Natural Family Planning ☐ Rhythm ☐ Withdrawal ☐ IUD (type) _____ ☐ Pill (type)_____
Sexually Transmitted Infections? ☐ Herpes ☐ Chlamydia ☐ Gonorrhea ☐ HPV Was this treated? ☐ Yes ☐ No
Sexual Dysfunction problems?
SOCIAL HISTORY
☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** **Spouse/partner name-**_____
Smoking? ☐ **Yes** ☐ **No** **# of packs per day-**_____ **# of years used-**_____
Alcohol? ☐ **Yes** ☐ **No** **# of drinks per week-**_____
Substance abuse? ☐ **Yes** ☐ **No**
Age of first intercourse? _____ **# of partners**_____
Currently sexually active? ☐ **Yes** ☐ **No**
Domestic abuse? ☐ **Yes** ☐ **No**
Sexual Abuse? ☐ **Yes** ☐ **No**

	IF YOU CHECK YES TO ANY OF THE FOLLOWING, PLEASE PROVIDE THE DATE
Appendectomy	☐ Yes ☐ No Date:
Gall Bladder removal	☐ Yes ☐ No Date:
Breast surgery ☐ Yes ☐ No	If so, please check the following and was result cancerous of not: Biopsy: ☐ Yes ☐ No Right Breast ☐ Left Breast ☐ Date : _____ Mastectomy: ☐ Yes ☐ No Right Breast ☐ Left Breast ☐ Date: _____ Lumpectomy: ☐ Yes ☐ No Right Breast ☐ Left Breast ☐ Date: _____
Total Abdominal Hysterectomy	☐ Yes ☐ No (see below for ovaries) Date: _____
Vaginal Hysterectomy	☐ Yes ☐ No (see below for ovaries) Date: _____
Laparoscopy	☐ Yes ☐ No Date: Ovarian cysts: ☐ Yes ☐ No Right ☐ Left ☐ Both ☐ Endometriosis: ☐ Yes ☐ No
Removal of ovaries	☐ Yes ☐ No Right ☐ Left ☐ Both ☐ Date:
Cervical cryotherapy (freeze)	☐ Yes ☐ No Date:
Cervical LEEP cone	☐ Yes ☐ No Date:
Cervical cone biopsy	☐ Yes ☐ No Date:
Any other surgeries	☐ Yes ☐ No If yes, please list below
#1	Date:
#2	Date:
#3	Date:

FAMILY HISTORY					
Breast cancer ☐ Yes	☐ No	☐ Maternal	☐ Paternal	Who?	
Age of diagnosis?	Still alive?	☐ Yes	☐ No	Age of death	
Ovarian cancer ☐ Yes	☐ No	☐ Maternal	☐ Paternal	Who?	
Age of diagnosis?	Still alive?	☐ Yes	☐ No	Age of death	
Colon cancer ☐ Yes	☐ No	☐ Maternal	☐ Paternal	Who?	
Age of diagnosis?	Still alive?	☐ Yes	☐ No	Age of death?	
Heart disease ☐ Yes	☐ No	☐ Maternal	☐ Paternal	Who?	
Age of diagnosis?	Still alive?	☐ Yes	☐ No	Age of death?	
Diabetes ☐ Yes	☐ No	☐ Maternal	☐ Paternal	Who?	
Age of diagnosis?	Still alive?	☐ Yes	☐ No	Age of death?	

ANY ALLERGIES (PLEASE LIST BELOW)

MEDICAL HISTORY (PLEASE CHECK WHICH APPLIES TO YOU)			
Cardiovascular:	☐ Heart Attack ☐ Artery disease ☐ Angina ☐ CHF ☐ High BP ☐ High Cholesterol		
Endocrine:	☐ Diabetes ☐ Low Thyroid ☐ High Thyroid		
Respiratory:	☐ Asthma ☐ Allergies		
Immune:	☐ HIV+		
Gastrointestinal:	☐ Reflux ☐ Hepatitis ☐ Irritable Bowel ☐ Colitis		
Genito-urinary:	☐ Stones ☐ Kidney infection ☐ Chronic UTI		
Musculoskeletal:	☐ Arthritis ☐ Osteoporosis ☐ Osteopenia		
Psychiatric:	☐ Depression ☐ Anxiety ☐ PMS ☐ Bipolar ☐ Post-partum depression		
Neurological:	☐ Stroke ☐ Mini-stroke ☐ M.S. ☐ Seizures ☐ Migraines		
Rheumatology:	☐ Fibromyalgia ☐ Lupus		
Hematology/oncology:	☐ Factor 5 ☐ MTHFR ☐ Blood clots/thrombophilia		
THE MEDICATIONS THAT YOU TAKE		**DOSE**	**HOW FREQUENTLY (PLEASE LIST HERBAL SUPPLEMENTS ALSO)**