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?	**Date of last menstrual 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 ☐ Domestic Partner ☐ Same Sex Partner	
Age of first intercourse? _____	**# of partners _____**
Currently sexually active? ☐ Yes ☐ No	with Male ☐ with Female ☐ with Both ☐
Domestic abuse? ☐ Yes ☐ No	
Sexual abuse? ☐ Yes ☐ No	
Smoking? ☐ Yes ☐ No	**# of packs per day ____ # of years used ____**
Alcohol? ☐ Yes ☐ No	**# of drinks per day ____ # of drinks per week ____**
Substance 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 ALL THAT APPLY 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
Genitourinary:	☐ 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

PLEASE LIST ANY MEDICATIONS AND HERBAL SUPPLEMENTS THAT YOU TAKE	DOSE	HOW FREQUENTLY (PLEASE LIST HERBAL SUPPLEMENTS ALSO)

Name and location of pharmacy that you use: _____

Phone number of pharmacy: _____