MEDICAL INFORMATION FORM
(The information on this sheet is confidential)

WOMEN'S CARE MEDICAL GROUP

Patient Name:_____ **Age**_____ **Today's Date**_____
last first middle initial

A. OB/GYN HISTORY:

YOUR MENSTRUAL HISTORY (WHEN NOT TAKING BIRTH CONTROL PILLS):

AGE STARTED	NO. DAYS OF FLOW	AMOUNT OF FLOW LIGHT	AVE	HEAVY	ANY CRAMPS	ANY PRE-MENSTRUAL TENSION	MENSTRUAL CYCLE (NO. OF DAYS FROM FIRST DAY OF ONE PERIOD TO FIRST DAY OF NEXT PERIOD)	ARE YOUR CYCLES REGULAR	IRREGULAR

YOUR PREGNANCY HISTORY:

TOTAL NO. OF PREGNANCIES	NO. OF LIVE BIRTHS	NO. OF PREMATURES	NO. OF MISCARRIAGES	ABORTIONS	NO. OF STILL BIRTHS	NO. OF CHILDREN ALIVE	AGES OF OLDEST	YOUNGEST

Problems with pregnancy?_____

What method of contraception are you and your partner using now?_____ **Painful Intercourse?** ☐ Yes ☐ No

B. MEDICAL HISTORY:

Please answer ALL questions by checking "YES" or "NO" in the appropriate box provided.

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Heart Trouble	☐	☐	Cortisone Medicine	☐	☐	Venereal Disease	☐	☐	Hemophilia
☐	☐	Heart Murmur	☐	☐	Diabetes	☐	☐	AIDS	☐	☐	Allergies
☐	☐	Mitral Valve Prolapse	☐	☐	Blood Transfusion	☐	☐	Herpes	☐	☐	Pelvic Infection
☐	☐	Rheumatic Fever	☐	☐	Ulcers	☐	☐	Asthma	☐	☐	Psychiatric Care
☐	☐	Heart Surgery	☐	☐	Kidney Trouble	☐	☐	Lung Disease	☐	☐	Nervousness
☐	☐	Stroke	☐	☐	Liver Disease	☐	☐	Phlebitis	☐	☐	Fainting or Dizziness
☐	☐	High Blood Pressure	☐	☐	Glandular Disease (Thyroid, etc.)	☐	☐	Blood Disease	☐	☐	Tuberculosis
☐	☐	Low Blood Pressure				☐	☐	Anemia	☐	☐	Chest Pain, Shortness of Breath
☐	☐	Breast Problem	☐	☐	Hepatitis B (serum)	☐	☐	Poor Bladder Control			
☐	☐	Abnormal Pap	☐	☐	Yellow Jaundice	☐	☐	Excessive Alcohol Intake	☐	☐	Blood in Stool
☐	☐	Epilepsy or Seizures	☐	☐	Drug Addiction	☐	☐	In-utero DES Exposure	☐	☐	Rapid Weight Loss
☐	☐	Cancer	☐	☐	Smoking	☐	☐	Nagging Cough, Hoarseness	☐	☐	Change in Bowel/ Bladder Habits
☐	☐	Difficulty in Swallowing	☐	☐	Change in Mole/Wart						

Other medical problems? ☐ Yes ☐ No Describe_____

Have you ever had any major operations?_____

Are you under another doctor's care?_____

Allergy (To Medication)_____ Medications taken regularly_____

C. FAMILY HISTORY:

Has any Relative ever had...		YES	NO	Who		YES	NO	Who
Cancer of:	Breast	☐	☐		Diabetes	☐	☐	
	Uterus	☐	☐		Heart Trouble	☐	☐	
	Ovary	☐	☐		High Blood Pressure	☐	☐	
	Cervix	☐	☐		Stroke	☐	☐	
	Colon/Stomach	☐	☐		Epilepsy	☐	☐	
	Others	☐	☐		(others)	☐	☐	

X_____
PATIENT SIGNATURE (PARENT OR GAURDIAN)

MEDICAL UPDATES_____

I have read my MEDICAL HISTORY above and confirm that it adequately states past and present condition.

TODAY'S DATE	CHANGES IN HEALTH/MEDICATIONS		INITIAL	REVIEWED BY
	☐None			DR._____
	☐None			DR._____
	☐None			DR._____
	☐None			DR._____
	☐None			DR._____