Prince William OB/GYN Associates, Ltd.
MEDICAL HISTORY

Name____Birthdate_____/_____/_____Date________________
_
Reason for
visit____

YOUR PAST HEALTH

Please circle any of the following you have had:

Migraine Headaches
Heart Disease
High Cholesterol
Kidney Disease
Urinary Problems
Liver Disease
Hepatitis
Ulcers
High blood pressure
Stroke
Cancer
Blood transfusion
Genital Herpes
Genital Warts
Pelvic Infection
Abnormal Pap
Gallbladder Disease
Bowel Problems
Diabetes
Thyroid Disease
Seizures
Depression
Substance abuse
Breast disease
No
Back problems
Skin problems
Lung disease
Varicose Veins
Asthma
Anemia
Blood clot/Embolism
Phlebitis
Sexual or physical abuse
Blood disorder

Please list any other illnesses or special concerns:
____
____

OPERATIONS

Year Operation
____
____
____
____

YOUR FAMILY HISTORY

Please circle any of the following occurring in blood relatives

Breast cancer
Ovarian cancer
Bowel cancer
Heart disease
Mental Illness
Blood clots in legs or lungs
Heart attack or stroke before age 50
Cystic Fibrosis
Thyroid or gland problems
Diabetes
High blood pressure
Blood disorders
Kidney disease
Birth Defects
Uterine Cancer
Osteoporosis

Reviewed by ______________________________

Date:______________________________

MENSTRUAL HISTORY

Age when periods began:_____________________
Age at menopause: ___________________________
Number of days from the start of one period to the start of the next: ___________________________
Number of day's period lasts: ___________________
Cycles regular? Yes No
Flow: scant moderate heavy
Severe cramping? Yes No
Spotting or bleeding between periods? Yes No
Bleeding after intercourse? Yes No
Method of contraception:_____________________
Do you need or desire contraception? Yes

PREGNANCY HISTORY

Number of Pregnancies:_______________________
Number of Live Births:________________________
Number of Miscarriages / Abortions:____________
Number of Cesarean Sections:__________________

GENERAL HEALTH

Do you smoke? Yes No
Packs per day_____________________________
Do you drink alcohol?
never rarely occasionally moderately
Do you perform monthly self-breast exams? Yes No
Do you exercise regularly? Yes No
Do you follow any special diet?_________________

Date of last Pap Smear:________________________
Date of last Mammogram:______________________
Date of last blood work:________________________

MEDICATIONS

Please list all present medications below:
____
____
____

ALLERGIES

____
____

Name of Primary Care MD:____________________
____

How did you hear about our practice?____