PLEASE FILL OUT BOTH SIDES

MANCHESTER OB-GYN ASSOCIATES
PERSONAL MEDICAL HISTORY

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY. THE INFORMATION YOU PROVIDE HERE WILL BE PART OF YOUR MEDICAL RECORD.

NAME_____ DOB_____ DATE OF LAST PERIOD_____

DRUG ALLERGIES: NO_____YES _____
IF YES, LIST:
_____
_____
_____
_____
OTHER ALLERGIES:_____
_____
ARE YOU ALLERGIC TO LATEX? NO____ YES _____

MEDICATIONS/VITAMINS/ HERBS/SUPPLEMENTS
NO _____ YES_____ PLEASE LIST:
_____DOSAGE_____
_____DOSAGE_____
_____DOSAGE_____
_____DOSAGE_____
_____DOSAGE_____
_____DOSAGE_____
PREFERRED LOCAL PHARMACY_____
_____

DO YOU SMOKE? NO____QUIT /WHEN_____ YES_____HOW MUCH_____PERDAY_____
ALCOHOL: NO _____ YES_____ # OF DRINKS _____ PER_____
CAFFEINE: NO_____ YES_____ TYPE_____AMOUNT_____ PER_____
STREET DRUGS: NO _____ YES _____ TYPE _____
EXERCISE: NO_____ YES_____ TYPE:_____FREQUENCY_____
SELF BREAST EXAM: NO_____ YES _____ YOUR AGE @ 1ST MENSTRUAL PERIOD_____
DOES YOUR PARTNER PHYSCIALLY HURT YOU OR THREATEN TO HURT YOU? NO _____ YES _____
HAS YOUR PARTNER FORCED YOU TO HAVE SEX OR PERFORM SEX ACTS WHEN YOU DID NOT WANT TO?
NO _____ YES _____
DOES YOUR PARTNER INSULT, SCREAM AT OR TALK DOWN TO YOU? NO _____ YES _____
DOES YOUR PARTNER CONTROL YOU OR ANY PART OF YOUR LIFE? NO _____ YES _____
ARE YOU AFRAID OF YOUR PARTNER? NO _____ YES _____
DO YOU WEAR YOUR SEATBELT? NO _____ YES _____
CURRENT FORM OF BIRTH CONTROL: _____
HOW LONG HAVE YOU USED THIS METHOD? _____

ANYONE IN YOUR FAMILY WITH THE FOLLOWING: CANCER, HEART DISEASE, HIGH BLOOD PRESSURE, DIABETES, OSTEOPOROSIS, HIGH CHOLESTEROL, THYROID DISEASE
PLEASE LIST AGE & CAUSE OF DEATH IF APPLICABLE
ADOPTED _____
FATHER NO_____ IF YES, WHAT? _____
MOTHER NO _____ _____
BROTHERS NO_____ _____
SISTERS NO_____ _____
MATERNAL GRANDMOTHER _____
MATERNAL GRANDFATHER _____
MATERNAL AUNTS/UNCLES _____
PATERNAL GRANDMOTHER _____
PATERNAL GRANDFATHER _____
PATERNAL AUNTS/UNCLES _____
OTHER? _____

PLEASE FILL OUT OTHER SIDE

PATIENT NAME:_____ DOB:_____

OTHER THAN CHILDBIRTH, ANY HOSPITALIZATIONS OR SURGERIES? NO_____ YES_____ PLEASE LIST:

_____ WHEN _____
_____ WHEN _____
_____ WHEN _____
_____ WHEN _____

ANY PERSONAL HISTORY OF THE FOLLOWING MEDICAL PROBLEMS?:

ASTHMA:	NO _____ YES _____	HEART ATTACK:	NO _____ YES _____
HYPERTENSION:	NO _____ YES _____	HEART DISEASE:	NO _____ YES _____
DIABETES:	NO _____ YES _____	STROKE:	NO _____ YES _____
THYROID DISEASE:	NO _____ YES _____	CHRONIC PAIN:	NO _____ YES _____
CHOLESTEROL:	NO _____ YES _____	ANXIETY/DEPRESSION:	NO _____ YES _____
ABNORMAL PAP:	NO _____ YES _____	MIGRAINES:	NO _____ YES _____
BLOOD CLOTS:	NO _____ YES _____		

VASCULAR PROBLEMS: NO _____ YES _____ TYPE_____
NEUROLOGICAL PROBLEMS: NO _____ YES _____ TYPE_____
CANCER: NO_____ YES_____ TYPE _____

OBSTERICAL HISTORY:

HAVE YOU EVER BEEN PREGNANT? NO_____ IF NO, SKIP TO THE NEXT SECTION

YES _____ HOW MANY TIMES? _____

MISCARRIAGE: NO _____ YES _____ IF YES, HOW MANY? _____
ECTOPIC: NO _____ YES _____ IF YES, HOW MANY? _____
TERMINATIONS: NO _____ YES _____ IF YES, HOW MANY? _____
STILLBIRTHS: NO _____ YES _____ IF YES, HOW MANY? _____
LIVE BIRTHS: _____ VAGINAL _____ C-SECTION _____
IF APPLICABLE, ARE YOU PLANNING TO HAVE ANOTHER CHILD? _____

CHECK THOSE BELOW IF YOU HAVE ANY *CURRENT* PROBLEMS WITH:

FATIGUE _____	FEVER _____	NIGHT SWEATS _____
VISION _____	HEARING _____	EAR OR NOSE DRAINAGE _____
COUGH _____	WHEEZING _____	SHORTNESS OF BREATH _____
PALPITATIONS _____	CHEST PAIN _____	
ABDOMINAL PAIN _____	VOMITING _____	PELVIC PAIN _____
CONSTIPATION _____	DIARRHEA _____	BLOOD IN STOOL _____
PROBLEMS WALKING _____	BONE OR JOINT PAIN _____	BRUISE EASILY _____
RASH _____	WHERE _____	
ANXIETY _____	DEPRESSION _____	
PAINFUL PERIODS _____	HEAVY PERIODS _____	HOW FREQUENT _____

DO YOU FEEL YOUR PERIODS IMPACT THE QUALITY OF YOUR LIFE? NO _____ YES _____
BLOOD IN URINE _____ URINARY FREQUENCY _____ PAINFUL URINATION _____
LEAK URINE WHEN YOU COUGH, LAUGH OR SNEEZE? _____

PLEASE BE SURE <u>BOTH</u> SIDES ARE COMPLETED!