Woodland Women's Health Associates **Patient Medical History Form**

Name _____ Date of Birth _____

Family Physician_____ Reason for Coming _____

Do you consent to release of information to your other MDs? Yes _____ No _____

Medical History of Importance to You:

_____

_____

Present Medications _____

Allergies to Medications _____

Have you had any operations? _____

Have you ever received blood transfusions? Yes _____ No _____

Does your religion have a conflict with the use of blood? Yes _____ No _____

GYN HISTORY

Menses - Regular _____ Irregular _____ Began at age _____
Periods last _____ days
Flow is light _____ moderate _____ heavy _____
Cramps: none _____ mild _____ moderate _____
Medications used for cramps _____
Periods stopped at age _____

Pap Smear - Last done _____ Normal _____ Abnormal _____
History of abnormal pap smear? Yes _____ No _____
If yes, treatment and date _____

Mammogram - Last done _____ Normal _____ Abnormal _____
History of abnormal mammogram? Yes _____ No _____
If yes, treatment and date _____

Contraception - None _____ Pill _____ IUD _____ Diaphragm _____ Condoms _____
Foam Suppositories _____ Vasectomy _____ Tubal Ligation _____
History of sexually transmitted disease? Yes _____ No _____
History of DES Exposure? Yes _____ No _____ Unknown _____

Pregnancies - Total Number _____ Living Children _____ Multiple Preg. _____
Preterm Deliveries _____ C/Sections _____ Miscarriages _____

FAMILY HISTORY

Heart Disease _____ Hypertension _____ Stroke _____ Diabetes _____ Kidney Disease _____
Bleeding Problems _____ Cancer _____ Anesthesia Problems _____

Date _____ Signature _____