PATIENT MEDICAL HISTORY AND DISCLOSURE

Patient Name _____ Date _____

I. Check "Yes" for each medical problem that you have had, and write the date that you had it. If you have not had a condition, you must check "No."

Medical Condition	Check One. If yes, date?	Medical Condition	Check One. If yes, date?
High Blood Pressure	☐ Yes ☐ No _____	Dizzy/Fainting Spells	☐ Yes ☐ No _____
Blood Clotting Disorders	☐ Yes ☐ No _____	Circulatory Problems	☐ Yes ☐ No _____
Heart Disease or Murmur	☐ Yes ☐ No _____	Varicose Veins	☐ Yes ☐ No _____
Mitral Valve Prolapse	☐ Yes ☐ No _____	Low Blood Sugar	☐ Yes ☐ No _____
Rheumatic Fever	☐ Yes ☐ No _____	Pneumonia	☐ Yes ☐ No _____
Thyroid Problems	☐ Yes ☐ No _____	Eating Disorders	☐ Yes ☐ No _____
Diabetes	☐ Yes ☐ No _____	Liver Disease	☐ Yes ☐ No _____
Epilepsy/Seizures	☐ Yes ☐ No _____	Tuberculosis	☐ Yes ☐ No _____
Anemia	☐ Yes ☐ No _____	Sickle Cell Trait/Disease	☐ Yes ☐ No _____
Excessive Bleeding	☐ Yes ☐ No _____	Gall Bladder Disorder	☐ Yes ☐ No _____
Asthma	☐ Yes ☐ No _____	Depression	☐ Yes ☐ No _____
Drug Addiction	☐ Yes ☐ No _____	Pain with Intercourse	☐ Yes ☐ No _____
AIDS Exposure	☐ Yes ☐ No _____	Herpes/Recurrent	☐ Yes ☐ No _____
Pelvic Inflammatory Disease	☐ Yes ☐ No _____	Venereal Warts/Recurrent	☐ Yes ☐ No _____
Problems w/Uterus/Tumor	☐ Yes ☐ No _____	Syphilis	☐ Yes ☐ No _____
Problems w/Ovaries/Cysts	☐ Yes ☐ No _____	Gonorrhea	☐ Yes ☐ No _____
Hepatitis	☐ Yes ☐ No _____	Chlamydia	☐ Yes ☐ No _____
Malignancy/Cancer	☐ Yes ☐ No _____	Endometriosis	☐ Yes ☐ No _____
Psychiatric Care	☐ Yes ☐ No _____	Breast Problems	☐ Yes ☐ No _____
Urinary Tract/Bladder Infection	☐ Yes ☐ No _____	DES Exposure	☐ Yes ☐ No _____
Kidney Problems	☐ Yes ☐ No _____	Mononucleosis	☐ Yes ☐ No _____
Ulcers	☐ Yes ☐ No _____	Domestic Abuse	☐ Yes ☐ No _____
Migraine Headaches	☐ Yes ☐ No _____	Sexual Abuse	☐ Yes ☐ No _____
Severe Chest Pain	☐ Yes ☐ No _____	Learning Disabilities	☐ Yes ☐ No _____
Blurred Vision	☐ Yes ☐ No _____	Currently Breast Feeding	☐ Yes ☐ No _____

II. List any operations, or procedures on cervics, illnesses, or severe injuries you have had and the approximate month and year of each.

Condition	Date	Condition	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

III. List any family members (parents, grandparents, brothers, sisters) who have/had a hereditary illness or condition such as diabetes, cancer, heart disease, stroke, or bleeding disorders.

Family Member	Condition	Family Member	Condition
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IV. Answer the following questions to the best of your knowledge.

1. Are you allergic to any drugs? ☐ Yes ☐ No If yes, what? _____
2. Are you taking any medications at this time? ☐ Yes ☐ No If yes, what? _____
3. Are you using any street drugs? ☐ Yes ☐ No If yes, What _____
4. Do you drink alcoholic beverages every day? ☐ Yes ☐ No If yes, how many? _____
5. Do you smoke cigarettes every day? ☐ Yes ☐ No If yes, how many? _____
6. Do you drink caffeine every day? ☐ Yes ☐ No If yes, how much? _____
7. Do you take aspirin every day? ☐ Yes ☐ No If yes, how many? _____

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PATIENT MEDICAL HISTORY AND DISCLOSURE (Continued from front)

V. The following questions provide important information about your gynecological and pregnancy history.

1. What was the first day of your last normal period? ____/____/____ Have you spotted or bled since? ☐ Yes ☐ No
2. The flow of this period was (check one) ☐ normal ☐ heavy ☐ light
3. The flow of the period before that was (check one) ☐ normal ☐ heavy ☐ light
4. The flow of my periods in the past 6 months has been (check one) ☐ normal ☐ heavy ☐ light
5. At what age did you first get your period?_____ Are your periods regular? ☐ Yes ☐ No
6. At what age did you first have intercourse?_____
7. How many sexual partners have you had this year?_____ In the past five (5) years? _____
8. On the average, how many days do you usually flow?_____ Do you have cramps/pain? ☐ Yes ☐ No
9. How many days are between your periods?_____
10. Have you ever been pregnant before? ☐ Yes ☐ No (if yes, please complete the following section.)

Number of live births	_____	Dates ____/____ ____/____ ____/____ ____/____		Number of still births	_____	Dates ____/____ ____/____ ____/____ ____/____	
Number of Cesareans	_____	Dates ____/____ ____/____ ____/____ ____/____		Number of miscarriages	_____	Dates ____/____ ____/____ ____/____ ____/____	
Number of premature births	_____	Dates ____/____ ____/____ ____/____ ____/____		Number of D & C's	_____	Dates ____/____ ____/____ ____/____ ____/____	
Number of tubal (ectopic)	_____	Dates ____/____ ____/____ ____/____ ____/____		Number of Abortions	_____	Dates ____/____ ____/____ ____/____ ____/____	

11. What was the date of your last pap smear (if any)? ____/____ Place? _____
12. Have you ever had an abnormal pap smear? ☐ Yes ☐ No If yes, explain _____
13. Are you using birth control at this time? ☐ Yes ☐ No What? _____
14. What birth control method or information do you now desire? _____
15. Are you experiencing any problems today? ☐ Yes ☐ No If yes, explain _____
16. Check any of the methods of birth control you have used or are now using and fill in the information for each.

Method	Used How Long?	Problems Experienced
☐ Pills	_____	_____
☐ IUD	_____	_____
☐ Diaphragm	_____	_____
☐ Foam or Suppositories	_____	_____
☐ Condoms	_____	_____
☐ Other	_____	_____

I have fully and completely told my past and present medical history, and I consent to the Center relying on the information I provided as complete and accurate.

Patient_____Witness_____Date____/____/____

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