PATIENT HISTORY FORM

SSM Health Medical Group

Name: ____________________________DOB:____/____/________

Reason for visit today:____

First day of last menstrual period or menopause: ___/____/______

Current birth control method: __________________________________

Approximate date of Last pap smear:____________ Results:____________

Approximate date of Last Mammogram: :____________ Results:____________

Approximate date of Last Bone Density: :____________ Results:____________

Approximate date of Last Cholesterol Test: :____________ Results:____________

Approximate date of Last Colonoscopy: :____________ Results:____________

Past Medical & Social History

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery:

____

____

Have you ever smoked? Yes No

Do you currently smoke? Yes No

How much do you smoke?___________

Do you drink alcohol? Yes No

How often do you drink?_____________

Are you on any medications? Yes No

If Yes, please list:

____

____

Do you have any drug allergies? Yes No

If Yes, please explain:

____

____

Family History – List all serious illnesses in your immediate family:

____

____

Name: ______________________________DOB:____/____/_______

OB History:

Total # of Pregnancies:______ # of Abortions:______ # of miscarriages:_____

Past Pregnancies

Date Month/Day/Year	GA Weeks	Length of Labor	Birth weight	Sex M/F	Type of Delivery	Anesthesia Yes/No	Place of Delivery	Preterm Labor Yes/No	Comments

Review of Systems

Do you have any problems relating to the following areas? The doctor will ask you for details on all "Yes" Answers.

Periods (Hysterectomy)

Are your periods regular?
How Often?
Every ______days/weeks
Flow lasts _________days
Do you have cramps? Y N
If so, Mild Mod Severe

GYN History

Any prior abnormal pap? Y N
If so, any treatment?___________
Any history of sexually transmitted diseases? Y N
List:______________________
____

Pelvic

Painful urination Y N
Frequent urination Y N
Urinary Leakage Y N
Pelvic pain Y N
Abdominal Pain Y N

Intercourse:

Pain? Y N Bleed? Y N

Constitutional Symptoms

Fever Y N
Chills Y N
Headache Y N

Respiratory

Wheezing Y N
Frequent cough Y N
Shortness of breath Y N
Asthma Y N

Breast

Pain Y N
Lump Y N
Discharge Y N
Do you practice regular self - breast exams? Y N

Menopausal Symptoms

Hot flashes Y N
Night Sweats Y N
Memory loss Y N
Emotional swings Y N

Psychologic

Depression Y N
Sexual problems Y N

Eyes

Vision change Y N
Pain Y N
Glaucoma Y N

Skin

Rash Y N
Boils Y N

Health Maintenance

Do you take herbals? Y N
Do you take calcium? Y N
Do you Exercise? Y N
What type?________________

Musculoskeletal

Joint pain Y N
Neck Pain Y N
Back Pain Y N

Circulation

Blood clots Y N
Thrombophlebitis Y N

Gastrotintestinal

Diarrhea/constipation Y N
Nausea/Vomiting Y N
Bloody Stools Y N
Jaundice/Hepatitis Y N
Gall Bladder Disease Y N

Allergies

Hay Fever Y N
Other:____________________