

Women's Institute for Gynecology & Minimally Invasive Surgery, LLC

Medical History Form

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

Name _____ Age _____ Birth Date _____ Date _____
 Chief Complaint _____
 List all medication allergies _____
 List present medications/supplements _____

Surgical History:		OB/GYN	OTHER	
Date	Procedure	Date	Procedure	

Past Medical Illness History (NO SURGERY):

		Hospitalized?		
Date	Illness		Yes	No

Review Of Medical History: Do you have now or have you ever had any of the following?

	No	Yes	Please explain
Anemia/Blood Disorder			
Arthritis			
Blood Transfusions			
Bowel Disorders			
Breast Disease			
Blood Clot/Phlebitis			
Cancer			
Diabetes			
DES Exposure			
Excessive Bleeding			
Gall Bladder			
H Hernia/Peptic Ulcer			
Headache/Migraine			
Heart Disease			
Hypertension			
Infertility			
Jaundice/Hepatitis			
Kidney Disease			
Respiratory Disease			
Seizure Disorder			
Skin Disease			
Thyroid Disease			
Urinary Infections			
STD's			

Do you have a FAMILY history of:	No	Yes	Who, What Type?
1. Heart Disease	_____	_____	_____
2. High Blood Pressure	_____	_____	_____
3. Diabetes	_____	_____	_____
4. Stroke	_____	_____	_____
5. Cancer	_____	_____	_____
6. Thyroid Disease/Cancer	_____	_____	_____
7. Other Disease	_____	_____	_____

Tests (give date last done):

	No	Yes	Not Sure	Never	Results
Pap Smear	_____	_____	_____	_____	_____
Breast Exam	_____	_____	_____	_____	_____
Mammography	_____	_____	_____	_____	_____
Rectal Exam	_____	_____	_____	_____	_____
Sigmoidoscopy	_____	_____	_____	_____	_____
Colonoscopy	_____	_____	_____	_____	_____
Cholesterol	_____	_____	_____	_____	_____
Flu Shot	_____	_____	_____	_____	_____
Pneumonia Shot	_____	_____	_____	_____	_____
Thyroid Profile	_____	_____	_____	_____	_____
Tetanus (DPT)	_____	_____	_____	_____	_____
Bone Density Test	_____	_____	_____	_____	_____

Pregnancies:

Children Born Alive _____ #C-sections _____
 # Prematures _____ # Stillborns _____ #Miscarriages _____
 #Abortions _____

Describe any complications: _____

Your Personal Habits: Do you?

	No	Yes	Explain
Regularly exercise (3-4 times per week)	_____	_____	_____
Use illegal drugs	_____	_____	_____
Use alcohol	_____	_____	_____
Were you a heavy drinker?	_____	_____	_____
Smoke	_____	_____	_____
If ever, when did you stop?	_____	_____	_____
Have an Eating Disorder?	_____	_____	_____
If yes, circle Anorexia Bulemia	_____	_____	_____
Have you ever been abused?	_____	_____	_____
Currently?	_____	_____	_____
Do you feel safe in your home?	_____	_____	_____
Do you have sex with men _____ women _____ both _____			
Any concerns?			

X _____

Signature

Date

The above is true and correct to the best of my belief.