

Terry Allen MD & Scott Forrest MD, PLLC
PATIENT HISTORY FORM

Name: _____	Age: _____	Date: _____
Reason for visit: <input type="checkbox"/> Annual exam <input type="checkbox"/> Problem visit (explain) _____ _____		
Who referred you to us? <input type="checkbox"/> Physician _____ <input type="checkbox"/> Insurance <input type="checkbox"/> Internet <input type="checkbox"/> Friend <input type="checkbox"/> Family		
Medications: <input type="checkbox"/> None _____ _____ _____ _____	Allergies: <input type="checkbox"/> None _____ _____ _____ _____	

Past Medical History: (circle all that apply)

Asthma	Heart Disease	Lupus
Anemia	Hepatitis/Liver Disease	Mitral Valve Prolapse
Bleeding Disorder	High Cholesterol	Osteoporosis
Blood Clot	Hypertension	Rheumatic Fever
Cancer (Type: _____)	Hypothyroidism	Seizure Disorder
Depression/Psychiatric Disease	Hyperthyroidism	Tuberculosis
Diabetes	HIV/AIDS	Ulcers
Drug/Alcohol/Substance Abuse	Irritable Bowel Syndrome	
Eating Disorder	Kidney Disease/ Stones	
Other _____	_____	_____

Past Surgical History:

Date	Surgery	Date	Surgery
_____	_____	_____	_____
_____	_____	_____	_____

Past Obstetrical History:

Number of pregnancies: _____ Number of miscarriages: _____
 Number of living children: _____ Number of terminations: _____

Date	Vaginal/C. Section	Gestational Age	Weight of Baby	Name of Baby
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Previous Pregnancy Problems: (circle all that apply)

Baby weight over 9 pounds	Birth injury to baby	Hemorrhage/Transfusion
Baby weight under 6 pounds	Birth injury to mother	Rapid labor
Premature labor (less than 37 wks)	High blood pressure	Anesthesia reaction
Premature delivery	Gestational diabetes	Other: _____

Name: _____

Gynecologic History:

Menarche (age of first menses): _____ Date of last menses: _____
How many days does menses last? _____ How many days between menses? _____
Menses flow is? Light Moderate Heavy Painful None/Menopausal
Form of birth control? None Pill Patch Vaginal ring IUD Depo Provera
 Rhythm Method Condoms Tubal ligation Vasectomy Trying to conceive
Are you sexually active? Yes No Do you have pain during sex? Yes No
Lifetime number of sexual partners? _____ Have you been abused sexually? Yes No
Year of last Pap Smear _____ Year of last Mammogram _____
Year of last Colonoscopy _____ Year of last Bone Density _____

Previous or Current Gynecologic Problems: (circle all that apply)

Abnormal Pap Smear	Uterine Fibroids	Chlamydia
Precancerous cells on cervix	Uterine Polyps	Gonorrhea
Surgery or freezing of cervix	Irregular / Painful Menses	Genital Herpes
Ovarian cysts	Urinary Incontinence	Genital Warts/ HPV
Endometriosis	Recurrent yeast infections	Trichomoniasis
Premenstrual syndrome	Recurrent vaginal infections	Syphilis

Family History: (circle all that apply) M=Mother, F= Father, S=Sister, B=Brother, MGP= Maternal grandparent, PGP= Paternal grandparent, C= Child

Breast Cancer	Heart Disease	Substance Abuse
Uterine Cancer	Hypertension	Psychiatric Disorder
Ovarian Cancer	Stroke	Thyroid Disorder
Cervical Cancer	High cholesterol	Lupus
Bleeding Disorder	Kidney Disease	Other: _____
Blood Clot	Diabetes	

Social History:

Single Married Separated Divorced Widowed
Do you smoke? No Yes (How much? _____, How long? _____)
Do you drink alcohol? No Rarely 2-4 drinks/week Daily History of abuse
Do you use illicit drugs? No Yes (Type? _____) History of abuse
Occupation: _____

Review of Systems: Do you have any of the following (circle all that apply)?

Chronic Headaches	Frequent Nausea	Numbness	Breast lump
Visual changes	Excessive Heartburn	Anxiety	Breast discharge
Hearing loss	Chronic constipation	Depression	Blood from nipple
Dizziness	Chronic diarrhea	Joint pain	Irregular menses
Chest Pain	Blood in stool	Muscle pain	Painful menses
Difficulty Breathing	Hemorrhoids	Weight loss	Vaginal discharge
Heart Palpitations	Bladder infections	Weight gain	Pelvic pain
Heart Murmur	Blood in urine	Fatigue	Painful intercourse
Chronic Cough	Painful urination	Excessive Thirst	Leakage of urine
Wheezing	Easy bruising	Heat intolerance	
Blood in sputum	Skin rash	Cold intolerance	