

**Murray Woman's Clinic PLLC
Medical History Form**

Name _____ Date of Birth _____ Social Security # _____

The following information will assist us in providing you the most excellent care. This information is a confidential record. **Please fill out both sides of this form completely.**

Have you ever had the following? (check all that apply)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Polycystic Ovarian Syndrome |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Lupus | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Blood Clot (lungs, legs) | <input type="checkbox"/> Hayfever/Allergies | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraines | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Heart Valve Disease | <input type="checkbox"/> Neurologic Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic Lung Disease | <input type="checkbox"/> Hepatitis: A B C | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Herpes | <input type="checkbox"/> Peptic Ulcers | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Phobias | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Exposure to DES |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Cancer—what kind? | |

Your most recent:	Date	Result	Your most recent:	Date	Result
Mammogram			Flu Vaccine		
PAP smear			Tetanus Vaccine		
Bone Density Scan			Pneumonia Vaccine		
Rectal/Stool Exam			Gardasil Vaccine		
Cholesterol Check			Tuberculosis Skin Test		

List all Surgeries and Procedures

Surgery/Procedure	Year Performed	Surgery/Procedure	Year Performed

List all prescription and over-the-counter medications and supplements you take regularly

Medication	Dose	Frequency (how often)	Prescribing Physician (or over the counter)

List all medication allergies and the reaction you have if you take them

Allergic To:	Reaction	Allergic To:	Reaction

Family History Are You Adopted? NO YES (If blood relative history unknown, skip to Gynecologic History)

Has any blood relative had any of the following? Indicate mother, father, siblings, children, grandparents, aunts, and uncles

Problem	Family Member	Age Onset	Problem	Family Member	Age Onset
Alcoholism			Heart Disease		
Asthma			Hypertension		
Bleeding Disorder			Kidney Disease		
Cancer-what kind			Mental Illness		
Cancer (continued)			Migraines		
Diabetes			Osteoporosis		
Epilepsy/Seizures			Stroke		
Glaucoma			Thyroid Disease		

Gynecologic History

Menopause NO YES Since age: _____
 First day of most recent menstrual period: _____
 How many days do your periods last? _____
 Length of entire menstrual cycle: _____
 Regular periods? NO YES
 Pain with periods? NO YES

Pregnancy History

Have you ever been pregnant? NO YES
 Number of pregnancies: _____
 How many children have you delivered? _____
 How many are still living? _____
 Have you ever had a miscarriage or stillborn? NO YES
 How many? _____
 Have you ever had an abortion? NO YES
 How many? _____

Current Birth Control Method (check all that apply)

- Virgin
- Natural Family
- Condoms
- IUD
- Nuvaring
- Tubal Ligation
- Abstinent
- Planning
- Foam/Gel
- Pill
- Depo-Provera
- None
- Withdrawal
- Diaphragm
- Patch
- Vasectomy
- Hysterectomy

Obstetric History

Date of delivery, miscarriage, abortion	Sex of Baby	Weight of Baby at birth?	Vaginal?	C-section?	Location/ Doctor	Complications in pregnancy or delivery

Social History

Marital status: Single Engaged Married Divorced Widowed
 Do you smoke? Never Former (Quit when? _____) Yes (How much per day? _____) Age Started Smoking: _____
 Do you drink alcohol? Never Yes (How much and how often? _____)
 History of illegal drug use? Never Yes (What kind, how much and how often? _____)
 Do you drink caffeine? No Yes (How much and how often? _____)
 How much exercise do you get? Sedentary 1-2 times/mo 1-2 times/wk 3-4 times/wk Nearly every day Daily

Please check any symptoms you are currently having now:

- Weight loss-recent
- New Breast Lumps
- Vomiting
- Urinary Incontinence
- Back Pain-Chronic
- Fever
- Nipple Discharge
- Constipation
- Painful Sex
- Hot Flashes
- Chills
- Chest Pain
- Diarrhea
- Painful Urination
- Night Sweats
- Loss of Appetite
- Loss of Consciousness
- Blood in Stools
- Bleeding after Sex
- Excessive Urination
- Frequent Head Aches
- Lower leg swelling
- Narrow Stools
- Rash
- Excessive Thirst
- Neck pain
- Shortness of Breath
- Urinary Urgency
- Changes in Skin Moles
- Anxiety
- Dizziness
- Wheezing
- Nighttime Urination
- Muscle Weakness
- Depression
- Frequent Sore Throat
- Chronic Cough
- Urinary Frequency
- Numbness
- Excessive Moodiness
- Nose Bleeds
- Nausea
- Blood in Urine
- Joint Pain
- Difficulty Sleeping
- Bruise Easily
- Easy Bleeding