PennState Health

Women's Care

MEDICAL HISTORY FORM

2494 Bernville Road, Suite 100, Reading PA 19605 | 610-378-2899

Date: _____

Name_____ _____ _____
First MI Last

Birthdate_____ SS#_____

MEDICAL INFORMATION

Medication Allergies:

_____
_____
_____

Other Allergies:

_____
_____

Current medications (including non-prescription medications and vitamins):

Drug	Dose

Previous medical events:

	No	Yes	Date	Treated By
Stroke	○	○		
Thyroid Disorders	○	○		
Other: (please list) _____				

PAST SURGICAL HISTORY

Operation	Date	Surgeon	Hospital

List any other hospitalizations not yet mentioned:

_____

_____

FAMILY HISTORY (Parents, siblings, children, grandparents,aunts,uncles)

☐ Please check here if you are adopted or have an unknown history. You may skip this section.

Age of mother_____ Age of father_____ #of sisters_____ #of brothers_____

Do any of your relatives have:

	No	Yes	List relative(s)
Diabetes	○	○	
Clotting disorder	○	○	
Heart disease	○	○	
High blood pressure	○	○	
High cholesterol	○	○	
Osteoporosis	○	○	
Breast cancer	○	○	
Colon cancer	○	○	
Other cancer: (please list) _____			

SOCIAL HISTORY

What is your marital status? ○ Married ○ Divorced ○ Single ○ Widowed

	No	Yes
Do you smoke	○	○ If yes, how many packs per day ____
Do you drink alcohol	○	○ If yes, how many drinks per day/week _____
Do you, or have you ever used recreational drugs	○	○ If yes, what type(s) _____
Do you wear a seatbelt	○	○
Have you been hit or physically abused by a partner	○	○
Have you been forced to have sexual activity against your will	○	○

SEXUAL HISTORY

If you have had intercourse, age at first intercourse_____
Are you currently sexually active? ○ No ○ Yes
Who are you sexually active with? ☐ Men and/or ☐ Women
Have you had a new partner in the last year? ○ No ○Yes
Total number of lifetime partners_____
What method of contraception are you using?_____

Have you ever had any of the following?

	No	Yes
Chlamydia	○	○
Genital Warts	○	○
Gonorrhea	○	○
Hepatitis (A,B,C)	○	○
Herpes	○	○
HIV	○	○
Human Papilloma Virus	○	○
Pelvic Inflammatory Disease	○	○
Syphilis	○	○

CURRENT OR PAST HISTORY

	No	Yes	When	Treated By
Anorexia/Bulimia	○	○		
Asthma/Lung Problems	○	○		
Bleeding Disorders	○	○		
Blood Clots in Legs or Lungs	○	○		
Blood Transfusion	○	○		
Cancer	○	○		
Depression/Anxiety	○	○		
Diabetes	○	○		
Heart Murmur	○	○		
High Blood Pressure	○	○		
High Cholesterol	○	○		
Kidney Infection, Stones	○	○		
Liver Disease or Jaundice	○	○		
Lupus/Autoimmune Disorder	○	○		
Seizure Disorder	○	○		
Stomach/Intestinal Disorder	○	○		

GYNECOLOGICAL HISTORY

Date of last menstrual period_____
Was it a normal period? ○ Yes ○ No
Age when periods started_____
Frequency of periods: Every _____days
Length of periods:_____days
Number of pads/tampons used on heaviest day_____
When was your last PAP smear?_____Was it normal? ○ Yes ○ No
Have you ever had an abnormal PAP smear? ○ Yes ○No
How was it evaluated and/or treated?_____
Do you perform monthly breast self-exams? ○ Yes ○No
When was your last mammogram?_____Was it normal?_____

Do you suffer from:

	No	Yes
Bleeding/spotting between periods	○	○
Flooding	○	○
Painful periods	○	○
Pain with intercourse	○	○
Vaginal discharge/odor	○	○
Breast pain unrelated to menses	○	○
Breast lump	○	○
Nipple discharge	○	○
Recurrent bladder infections	○	○
Vaginal dryness	○	○
Urinary leakage	○	○

OBSTETRICAL HISTORY

Total Number of Pregnancies _____
Total Number of Miscarriages _____
Total Number of Abortions _____

Please detail your deliveries:

Birth date	Full Term	Sex	Birth weight	Type of delivery	Complications	Baby's name
	○ Yes ○No	○ Male ○ Female		○ Vaginal ○ C-section		
	○ Yes ○ No	○ Male ○ Female		○ Vaginal ○ C-section		
	○ Yes ○ No	○ Male ○ Female		○ Vaginal ○ C-section		
	○ Yes ○ No	○ Male ○ Female		○ Vaginal ○ C-section		
	○ Yes ○ No	○Male ○ Female		○ Vaginal ○ C-section		