Fertility & Midwifery Care Center

G#_____

Patient Health History

Patient Name: _____ **Age:** _____ **DOB:** _____

Family Doctor: _____ **Referred By:** _____

Reason for visit: _____ **Date:** _____

Past Medical History

CONDITION	CURRENT	HISTORY	NO	CONDITION	CURRENT	HISTORY	NO
Abnormal PAP Smear				Herpes			
Anemia				Hypertension			
Anesthesia Complication				Infertility			
Anxiety				Kidney Stone			
Asthma				Liver Disease			
Blood Clots in Leg or Lungs				Lupus			
Blood Transfusion				Migraine			
Breast Disorder				Miscarriage			
Cancer of the Breast				MTHFR			
Cancer , other				Mitral Valve Prolapse			
Cardiovascular Disease				Pelvic Inflammatory Disease			
Depression				PCOS			
Diabetes				Seizures/Convulsions			
Endometriosis				Sexually Transmitted Diseases, STD's			
Epilepsy				Stroke			
Factor 5				Thyroid Disorder			
Fibromyalgia				Tuberculosis			
Heart Murmur				Ulcer			
Date of Last Pap Smear: / / ☐ Normal ☐ Abnormal				Date of Last Mammogram: / / ☐ Normal ☐ Abnormal			
Date of Last Dexa Scan: / / ☐ Normal Abnormal				Date of Last Colonoscopy: / / ☐ Normal ☐ Abnormal			
Other:							

Operations / Surgeries

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
1)		4)	
2)		5)	
3)		6)	

Medications

(Include prescriptions, over the counter, herbals & vitamins)

MEDICATION	DOSAGE	PRESCRIBING PHYSICIAN
1)		
2)		
3)		
4)		
5)		

SEE BACK

Medication Allergies

Do you have any drug allergies? ○ NO ○ YES (if yes, please list below)

MEDICATION	REACTION
1)	
2)	
3)	

Family Medical History

(Do any of your children, siblings, or parents have any of the following?)

ILLNESS	YES	RELATIONSHIP	ILLNESS	YES	RELATIONSHP
None			Cardiovascular Disease		
Adopted			Depression		
Blood Clot in Legs or Lungs			Diabetes		
Cancer, Breast			Hypertension		
Cancer, Colon			Osteoporosis		
Cancer, Ovarian			Polyp – anal/rectal/colon		
Cancer, Uterine			Stroke		
Cancer, Other			Thyroid Disorder		

Genetic History / Screening

(Self, partner, or other family member)

CONDITION	YES	RELATIONSHIP	CONDITION	YES	RELATIONSHIP
Cats – do you have exposure?			Diabetes – self only		
Chickenpox			Down Syndrome		
Congenital Heart Defect			Infertility		
Cystic Fibrosis			Rh Sensitized		
DES Exposure			Sickle Cell Anemia		

REPRODUCTIVE HISTORY

Age of first menses:	Cycle Interval (Number of days from start to start):
Menses duration (Number of days of bleeding):	Flow (circle): Light Medium Heavy
Number of Tampons per day:	Number of Pads per day:
Last Menstrual Period (date): / /	Certain of LMP date? (circle) YES NO
Menopause Status (circle): Pre Peri Post	Age at Menopause:
Method of Family Planning:	Sexually Active: (circle) YES NO
Bleeding between periods: (circle) YES NO	Pain with menses: (circle) YES NO

Pregnancy History

Total Pregnancies: _____ / Full Term: _____ / Preterm: _____ / Miscarriage: _____ / Abortion: _____ / Ectopic: _____ / Multiple: _____ / Living: _____

DATE	GESTATIONAL AGE	HOURS IN LABOR	BIRTH WEIGHT	GENDER	TYPE OF DELIVERY	ANESTHESIA	COMMENTS/ COMPLICATIONS	FACILITY/ PROVIDER

Social History

Marital Status (circle): Single Married Widowed Divorced Spouse/Partner Name:_____
Occupation:
Alcohol: _____Never _____Current _____Former _____Amount per week
Drugs: _____Never _____Current _____Former _____Type
Smoking: _____Never _____Current _____Former _____Amount per day
Amount of Exercise? Active Heavy Medium Minimal None (Sedentary)