Family Medical History

Please indicate below significant medical problems of family members. Indicate which family member by checking the appropriate column and the AGE OF ONSET: [ ] No Family History [ ] Adopted

	None	Mother	Father	Brother	Sister	Grand Mother (Maternal)	Grand Father (Maternal)	Grand Mother (Paternal)	Grand Father (Paternal)	Aunt	Uncle
Blood Clots											
Breast Cancer											
Cervical Cancer											
Colon Cancer											
Diabetes											
Ovarian Cancer											
Hypertension											
Stroke											
Uterine Cancer											
Other Cancer not mentioned											
Other Disease not mentioned											

Past Obstetrical/Gynecological Surgeries

Check all that apply or [ ] NONE

Surgery	Year
[ ] D&C	________
[ ] Hysteroscopy	________
[ ] Infertility Surgery	________
[ ] Tuboplasty	________
[ ] Tubal Ligation	________
[ ] Laparoscopy	________
[ ] Hysterectomy (vaginal)	________
[ ] Hysterectomy (abdominal)	________
[ ] Myomectomy	________
[ ] Biopsy	________
[ ] Ovarian Surgery	________
[ ] L Cyst(s) Removed Ovarian	________
[ ] R Cyst(s) Removed Ovarian	________
[ ] L Ovary Removed	________
[ ] R Ovary Removed	________
[ ] Vaginal or Bladder Repair for prolapsed or incontinence	________
[ ] Cesarean Section	________
[ ] Caposcopy	________
[ ] LEEP	________
[ ] Other (specify) ____________	________
____________	________

Past Non-OB/GYN Surgical History

Surgery	Month / Year	Complications

Past Gynecological History

[ ] Fibroids
[ ] Gonorrhea
[ ] Endometriosis
[ ] Ovarian Cysts
[ ] Syphilis
[ ] Infertility
[ ] Ovarian Cancer
[ ] Genital Herpes
[ ] Cervical Cancer
[ ] Chlamydia
[ ] HIV
[ ] Uterine Cancer
[ ] Pelvic Inflammatory Disease
[ ] Genital Warts
[ ] Other: ____________________

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Personal Medical History

Check if you currently have, or have had any of these medical problems in the past

[ ] Abuse/ Domestic Violence
[ ] Acid Reflux (GERO)
[ ] Acne
[ ] ADD/ADHD
[ ] Anemia
[ ] Anesthesia Complications
[ ] Anxiety Disorder
[ ] Arthritis
[ ] Asthma
[ ] Autoimmune/ Rheumatology
[ ] Birth Defects or Inherited Disease Blood Transfusions
[ ] Breast Cancer
[ ] Breast Problem
[ ] Cancer
[ ] Cardiac
[ ] Depression
[ ] Dermatology
[ ] Diabetes
 [ ] Diet Controlled
 [ ] Insulin Controlled
 [ ] Pill Controlled
 [ ] Gestational
[ ] Eating Disorder
[ ] Eczema
[ ] Endocrine
[ ] Endometriosis
[ ] Fibromyalgia
[ ] GI Problems
[ ] Headaches/ Migraines
[ ] Heart Disease
[ ] Heart Problems
[ ] Hepatitis
[ ] High Cholesterol
[ ] Hypertension
[ ] Infertility
[ ] Kidney Disease
[ ] Kidney or Bladder Problems
[ ] Lung Disease
[ ] Neurologic
[ ] Osteopenia
[ ] Osteoporosis
[ ] Ovarian Cancer
[ ] Polyp
[ ] Pre- Eclampsia
[ ] Psychiatric Illness
[ ] Respiratory
[ ] Stroke
[ ] Throm bophilias
[ ] Thyroid
[ ] Thyroid Problems
[ ] Varicosities
[ ] Other: ____________________