

### 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	Surgery	Year	Surgery	Year
<input type="checkbox"/> D&C	_____	<input type="checkbox"/> Hysterectomy (abdominal)	_____	<input type="checkbox"/> R Ovary Removed	_____
<input type="checkbox"/> Hysteroscopy	_____	<input type="checkbox"/> Myomectomy	_____	<input type="checkbox"/> Vaginal or Bladder Repair for prolapsed or incontinence	_____
<input type="checkbox"/> Infertility Surgery	_____	<input type="checkbox"/> Biopsy	_____	<input type="checkbox"/> Cesarean Section	_____
<input type="checkbox"/> Tuboplasty	_____	<input type="checkbox"/> Ovarian Surgery	_____	<input type="checkbox"/> Caposcopy	_____
<input type="checkbox"/> Tubal Ligation	_____	<input type="checkbox"/> L Cyst(s) Removed Ovarian	_____	<input type="checkbox"/> LEEP	_____
<input type="checkbox"/> Laparoscopy	_____	<input type="checkbox"/> R Cyst(s) Removed Ovarian	_____	<input type="checkbox"/> Other (specify) _____	_____
<input type="checkbox"/> Hysterectomy (vaginal)	_____	<input type="checkbox"/> L Ovary Removed	_____		

### Past Non-OB/GYN Surgical History

Surgery	Month / Year	Complications

### Past Gynecological History

<input type="checkbox"/> Fibroids	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Cervical Cancer	<input type="checkbox"/> Pelvic Inflammatory Disease
<input type="checkbox"/> Gonorrhoea	<input type="checkbox"/> Infertility	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Genital Warts
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Ovarian Cancer	<input type="checkbox"/> HIV	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Ovarian Cysts	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Uterine Cancer	

### Personal Medical History

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

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