

# MEDICAL HISTORY

PLEASE ANSWER ALL QUESTIONS ON THIS FORM

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Who Referred You Here? \_\_\_\_\_

What Is Your Main Problem For Coming To The Doctor Today? \_\_\_\_\_

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Are You Taking Any Medicines-Including Birth Control Pills \_\_\_\_\_

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Are You Allergic To Any Medications: Which: \_\_\_\_\_

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When Did Your Last Period Start? \_\_\_\_\_

When Was Your Last PAP Smear? \_\_\_\_\_

Have You Ever Had Herpes? \_\_\_\_\_

Have You Had Previous Surgery? \_\_\_\_\_

Date & Types: 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

List All Past Pregnancies:

Date	Length of Labor (Hours)	Sex	Birth Weight	Complications
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____