PATIENT MEDICAL HISTORY - Please print clearly

Date:

For physician use only

First & last name: ____________________ Preferred name: __________

Birthdate (m/d/y): ____________________ Pronoun: __________

Family doctor: ____________________ Carecard: __________

Address: ____________________

Home#: __________ Cel#: __________ Work#: __________

Ethnic origin: ☐ Caucasian ☐ Black ☐ First Nations
☐ Asian (specify) __________ ☐ Other (specify) __________

GYNECOLOGICAL/OBSTETRICAL HISTORY

At what age did your periods start? ____________________ UNSURE

First day of your last period / Age at start of menopause: __________ UNSURE

Your periods occur every __________ (# of days) and lasts about __________ (# of days)

Current method of contraception: (optional) ____________________

Past method(s) of contraception: (optional) ____________________

When was your last Pap smear? ____________________ UNSURE

Have you had the HPV vaccine? NO YES UNSURE

Total number of pregnancies: __________ Number of children: __________

MEDICAL HISTORY

Previous surgeries/hospitalizations: (Please list approximate year)

____

____

Current medications: ____________________

____

Medical allergies: NO YES If yes, please specify ____________________

____

Heart disease: NO YES Stroke: NO YES Osteoporosis: NO YES

Blood clots: NO YES Diabetes: NO YES Hypertension: NO YES

Cancer: NO YES If yes, please specify ____________________

Other major health issue(s): ____________________

____

FAMILY HISTORY

Do you have a family history of the above medical illnesses?: NO YES

If yes, please specify *(For example: Mother - Diabetes)*

____

____

SOCIAL HISTORY

Occupation: ____________________ Employer: ____________________

Alcohol: NO YES # drinks/wk: ____________________

Smoking: NO YES # cigs/day: ____________________

Vaping: NO YES specify: ____________________

Cannabis: NO YES specify: ____________________

Recreational drugs: NO YES specify: ____________________

Partner's name: (optional) ____________________

Partner's birthdate: (optional) ____________________

Note: This is a confidential record of your medical history that will be kept in the office. Information contained here will not be released to any person unless authorized by you to do so.