MEDICAL HISTORY

Date_____

Last Name	First Name	Middle	Date of Birth

Address	City	County	State	Zip

Age	Height	Weight	Race		
				Single_____	Married_____

Your Phone Number **You MUST provide us with your phone number and an emergency number**

Emergency Phone Number	Emergency Contact Person

Please check how you were referred to our clinic

Houston Yellow Pages		Houston White Business Pages		Spanish Yellow Pages	
Any Phone Book other than Houston		Physician_____		Friend/Former Patient	
Name of City_____		Clinic_____		Internet	

PERSONAL HISTORY

Have you ever had or needed treatment for:

yes	no		yes	no	
		a. Vaginal infection or Discharge			n. Bleeding Tendencies (Hemorrhage)
		b. Sexually Transmitted Disease (Syphilis, Gonorrhea, Trichomoniasis Herpes Chlamydia)			o. Lung Disease (Asthma, pneumonia, tuberculosis)
		c. Uterine Fibroids			p. Anemia or Sickle Cell
		d. Retroverted (tilted) Uterus			q. Liver Disease (Jaundice, hepatitis)
		e. Kidney or Bladder Infection			r. Rheumatic Fever
		f. Recent flu or high fever			s.. Epilepsy Seizures
		g. Severe Abdominal Pain			t. Diabetes
		h. Breast Disease or Cancer			u. Blurring of Vision or severe headaches
		i. Cervical Conization or Cryocauterization			v. Unexplained Bruising
		j. Antibiotics in the past month			w. Dizzy or Fainting Spells
		k. High or Low Blood Pressure or Heart Disease or Murmur			x. Severe Depression
		l. Blood Clots or Phlebitis			y. Joint Disease
		m. Needed a blood transfusion			z. Chronic Diarrhea or Constipation

If you have answered YES to any of the above, please identify by using the appropriate letter and follow with brief explanation:

Do you or any of your family members have any history of complications with anesthesia? If so, please describe

Please list previous hospitalizations for surgery:

	Yes	No				
Do you drink alcohol?			if YES how many drinks per day?		per week?	

Do you smoke?			**if YES how many packs per day?**			
Do you take Ibuprofen or Aspirin on a regular basis			**if Yes how often?**			
Have you taken any prescription/non prescription, legal/illegal drugs within 24 hours?			**if YES name the medication or drugs**		**time taken?**	

At what time did you last eat or drink (including water) _____a.m. _____p.m.

MEDICAL HISTORY

Name _____ **Date of birth**_____
Last First Middle

Please check any medications listed below to which you HAVE HAD an allergic reaction:

Penicillin		Tetracycline		Valium		Demerol		Lidocaine		Adhesive tape	
Ampicillin		Sulfa Drugs		Xylocaine		Aspirin		Betadine		Phenergan	
Erythromycin		Codeine		Nubain		Tylenol		Tetanus			

MENSTRUAL HISTORY

_____LMP(first day of your last normal period)	Was this a normal period?	____Yes	_____No

At approximately what age did your menstrual periods begin____	How many days does your period usually last ?____

Are your periods	_____regular (usually at the same time each month)	____irregular (skip around each month)

	yes	no		yes	no
Do you have tension before a period?			Do you experience depression before a period?		
Do you have cramps with a period?			Do you have pain with a period?		
Do you have hot flashes?			Is it possible that you are pregnant at this time?		

PREGNANCIES
DO NOT INCLUDE THIS PREGNANCY

Number of Previous Pregnancies		Number of Miscarriages	
Number of Full Term Pregnancies		Number of Abortions	
Number of Premature Births		Number of Cesareans	
Number of Ectopic Pregnancies			

Did you have excessive bleeding after any of the above?	___YES	___NO

Birthdate of youngest child, if applicable_____

BIRTH CONTROL

Are you using a birth control method? If yes, please check:

Birth Control Pills		Foam		IUD		Tubal Ligation	
Birth Control Patch		Condoms		Rhythm		Diaphragm/Cap	
Depo-Provera		Sponge		Withdrawal		Norplant	

Would you like us to assist you in obtaining a birth control method? [ ] yes [ ] no

FAMILY HISTORY

Use appropriate letter for family members if any of the following illnesses apply:
Mother (M) Father (F) Sister (S) Brother (B)

Heart Disease		Cancer		Obesity		Tuberculosis		Diabetes		Renal	

Mental Disease		**Epilepsy**		**Gout**		**Arthritis**		**Thyroid**		**other**	

What gynecological service can we provide you with this office visit?	**__Abortion**	**__Sono**	**__D&C**	**__other**
