

Desert West Obstetrics and Gynecology, Ltd.
Confidential Medical History

Name _____ Birthdate _____ Age _____ Date _____

Allergies to medications/food/environment	Reaction

Current Medications <small>(Prescription, over the counter, herbal)</small>	Prescribing Doctor	Dose	Instructions	Reason Used

What do you do so you don't become pregnant?

- Diaphragm Condoms Sponge Rhythm IUD
 Withdrawal Depo Provera Vasectomy Norplant Pills
 Essure Tuàal Ligation Implanon Ortho Evra Nuva Ring
 Other _____

First day of last period _____

What age were you when you started your first period? _____

Are your periods regular? _____

Is there bleeding between periods? _____

How often do your cycles occur? _____

For how many days do you bleed? _____

Flow is: scant mild mod severe incapacitating

Other symptoms with periods? _____

Date of last pap smear _____

Have you had an abnormal pap smear? No _____ Yes _____

Has this been treated? No _____ Yes _____

How? _____

Do you examine your breasts regularly? No _____ Yes _____

When was your last Mammogram (if any)? _____ Result _____

Do you have concerns about your breasts? _____

When was your last Bone Density (if any)? _____ Result _____

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Family History

Please complete if any of your close relatives have had any of the following:

Disease	Circle Yes/No	Family Member	Family Members 1st Name	Age of Onset	Age of Death	Cause of Death (Circle)
Cancer of Breast	Yes No					Yes No
Cancer of Ovary	Yes No					Yes No
Cancer of Uterus	Yes No					Yes No
Cancer of Cervix	Yes No					Yes No
Cancer of Colon	Yes No					Yes No
Diabetes	Yes No					Yes No
Tuberculosis (TB)	Yes No					Yes No
Heart Disease	Yes No					Yes No
High Blood Pressure	Yes No					Yes No
Other:						Yes No
						Yes No
						Yes No
						Yes No
						Yes No

Social History

Primary Language Spoken _____ Race _____
 Do you smoke? No _____ Yes _____ If yes, type of tobacco? _____ Number of years _____ Pks/day _____
 Do you drink alcohol? No _____ Yes _____ If yes, type of alcohol _____
 How often? _____ Amount _____ Last drink _____
 Do you consume caffeine? No _____ Yes _____ If yes, what kind? _____ Amount _____
 Do you use recreational drugs? No _____ Yes _____ If yes, what kind? _____
 Do you have a regular exercise program? No _____ Yes _____ Hours/week _____
 How many sexual partners do you have? None _____ One _____ 2-5 _____ 5+ _____
 Have you been exposed to sexual or physical violence or abuse? No _____ Yes _____
 Are there animals in the home? No _____ Yes _____ If yes, what kind? _____
 Is the patient the individual who cleans up after the animals? No _____ Yes _____
 If medically necessary, would you agree to a transfusion? No _____ Yes _____