



# Medical History Form

137 Clinic Drive  
Dothan, Alabama 36303

phone 334-699-2229  
fax 334-699-4084

web [aventawoman.com](http://aventawoman.com)

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Visit \_\_\_\_\_ DOB \_\_\_\_\_

Marital Status \_\_\_\_\_ Primary Care Physician \_\_\_\_\_ Previous Gynecologist \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_ Purpose of Today's Visit \_\_\_\_\_

## Personal Medical History (please check all that apply)

<b>CARDIOVASCULAR</b>	X	<b>GYNECOLOGIC</b>	X	<b>ENDOCRINE</b>	X	<b>PSYCHOLOGIC/NEUROLOGIC</b>	X
Cardiac catheterization		Abnormal pap		Adrenal gland disorder		ADHD	
DVT/blood clot		Bleeding after menopause		Diabetes		Anxiety	
Heart attack		Chlamydia		Pituitary disease		Bipolar disorder	
Heart murmur		Fibroids		Thyroid disease		Depression	
Heart problems		Gonorrhea		Other:		Postpartum depression	
High blood pressure		Herpes				Migraines	
High cholesterol		HPV		<b>KIDNEY</b>	X	Chronic headaches	
Pulmonary embolus		Ovarian cysts		Kidney infection		Seizures	
Stroke		Pelvic inflammatory disease		Kidney stones		Other:	
Other:		Trichomonas		Urinary tract infection			
		Other:		Other:		<b>OTHER</b>	X
<b>DIGESTIVE</b>	X					Glaucoma	
Constipation		<b>HEMATOLOGIC</b>	X	<b>MUSCULOSKELETAL</b>	X		
Crohn's disease		Anemia		Arthritis		<b>PULMONARY</b>	X
Diarrhea		B12 deficiency		Fracture		Asthma	
GERD (reflux)		Blood transfusions		Joint pain		Chronic bronchitis	
Hepatitis		Vitamin D deficiency		Osteopenia		COPD	
Irritable bowel syndrome		Sickle cell disease/trait		Osteoporosis		Pneumonia	
Stomach ulcers		Other:		Other:		Tuberculosis	
Ulcerative colitis						Other:	
Other:							
Anything else not listed above:							

## Surgeries and Hospitalizations

REASON	YEAR	REASON	YEAR

## Sexual History (circle what applies)

Have you ever had sexual intercourse?	Yes	No	Number of years since onset:
Are you sexually active now (within the last year)?	Yes	No	Number of partners in the last year:
Have you ever been diagnosed with an STD?	Yes	No	Type:
What are you currently using for birth control? (Circle ALL that apply)	Birth control pills	Condoms	Implanon
	Depo-Provera	None	Vasectomy
		Other:	Tubal
			IUD

## Menstrual History

PREMENOPAUSAL WOMEN				MENOPAUSAL WOMEN			
Age cycle began:	Breakthrough bleeding?	Yes	No	Age of menopause:			
Date of last cycle:	Flow?	Light	Medium	Heavy	Bleeding since?	Yes	No
Length of cycle:	Clots?	Yes	No	Hot flashes?	Yes	No	
Time between cycles:	Pain/cramps?	Yes	No	Vaginal dryness?	Yes	No	
What medications do you use for menstrual cramps?							

## Social History

Smoking	Yes	No	Packs per day:	Number of years:	Former smoker?	Yes	No
Alcohol	Yes	No	Drinks per day:	Drinks per week:	Number of years:		
Drug Use	Yes	No	Drugs used:				
Regular Exercise	Yes	No	How often:				
Occupation:							

## OB History *(Include miscarriages & abortions. Method of delivery: C-section, forceps, vacuum, or vaginal)*

Date	Method of Delivery	Weeks	Male or Female?	Weight	Physician & Facility	Pregnancy Complications

## Current Medications and Dosage *(include vitamins and herbal supplements)*

Medication and dosage	Medication and dosage	Medication and dosage

**Are you allergic to Latex?**

Yes No

**Allergies:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Preventative Care History

Procedure <i>(most recent)</i>	Date	Normal?	History of abnormal? <i>(List treatments, i.e. LEEP, cryo, laser, cold knife cone AND year of treatment)</i>
Pap		Yes No	Yes No
Mammogram		Yes No	Yes No
Colonoscopy		Yes No	Yes No
Bone Density		Yes No	Yes No

## Does anyone in your family have a history of:

Cancer	Relative(s)	Age at diagnosis
Breast cancer		
Uterine cancer		
Ovarian cancer		
Colon cancer		
Other cancer		

**To be completed by health care provider:** Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_