aventa
specialized women's care

Medical History Form

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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)*

CARDIOVASCULAR	✗	GYNECOLOGIC	✗	ENDOCRINE	✗	PSYCHOLOGIC/NEUROLOGIC	✗
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		**KIDNEY**	✗	Chronic headaches	
Pulmonary embolus		Ovarian cysts		Kidney infection		Seizures	
Stroke		Pelvic inflammatory disease		Kidney stones		Other:	
Other:		Trichomonas		Urinary tract infection			
		Other:		Other:		**OTHER**	✗
DIGESTIVE	✗					Glaucoma	
Constipation		**HEMATOLOGIC**	✗	**MUSCULOSKELETAL**	✗		
Crohn's disease		Anemia		Arthritis		**PULMONARY**	✗
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 | Vasectomy | Tubal | IUD | Depo-Provera | None | Other:	

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 *(most recent)*	Date	Normal?	History of abnormal? *(List treatments, i.e. LEEP, cryo, laser, cold knife cone AND year of treatment)*
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 _____