ASHMED VÁZQUEZ MD, PC
OBSTETRICS AND GYNECOLOGY

# Personal Health History

Patient Name _____ Date_____

**INITIAL INFORMATION:**

Race_____ Sexually Active? Yes____ No ____ Last Menstrual Period_____

**REASON FOR VISIT**

Well women visit ____ Urinary incontinence/Pelvic relaxation ____ Breast lump or mass ____

Contraceptive Refill ____ DepoProvera Injection ____ Menopausal Symptoms ____

Menstrual Disorders ____ Pelvic Pain____ Urinary tract symptoms ____ Vaginal Discharge ____

Vulvar Lessions _____ Pregnancy ____ Follow Up ____ Other _____

**ALLERGIES: List all allergies**

_____

**CHILDHOOD ILLNESS:**

Chicken Pox ____ Measles ____ Mumps ____ Rheumatic Fever ____ Rubella ____

**SURGERIES: List all surgeries** **TRANSFUSIONS:** Yes_____ No _____

_____

_____

**SMOKING STATUS:**

Current Every Day Smoker ____ Current Some Day Smoker ____

Former Smoker ____ Never Smoker ____

**ALCOHOL USE**

No ____ Yes ____ If Yes, how much? Every Day ____ Occasional ____ Social ____

**DRUG USE**

No ____ Yes____ If Yes, which? Cocaine ____ Marijuana ____

**CURRENT METHOD OF BIRTH CONTROL:**

Barrier Methods (Condoms, Diaphragm) ____ Tubal Ligation ____ Depo Provera ____

IUD Mirena ____ IUD Para Gard ____ Nuva Ring ____ Birth Control Pills ____ Vasectomy ____

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**GYNECOLOGICAL HISTORY:**

Menarche (First period) _____ Cycle Frequency _____ How Many Days?_____
Volume of Menses: Light ____ Moderate ____ Heavy ____
Last PAP Smear _____ Last Mammogram _____
Pelvic Inflammatory Disease (PID)? Yes ____ No ____ Sexually Transmitted Disease? Yes____ No____
If Yes, which? _____

**NUMBER OF PREGNANCIES:** (Including Miscarriages and Abortions) _____
Number of Deliveries _____ Term _____ Pre-Term _____

| Pregnancy # | Delivery Year | Type of Delivery | How Many Weeks? | Baby Sex | Baby Weight |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
| 7 | | | | | |

**MEDICATIONS**: List medications and over the counter drugs you are currently using.

| Medication | Dosage | How often? |
|---|---|---|
| **1.** _____ | | _____ |
| **2.** _____ | | _____ |
| **3.** _____ | | _____ |
| **4.** _____ | | _____ |
| **5.** _____ | | _____ |
| **6.** _____ | | _____ |
| **7.** _____ | | _____ |
| **8.** _____ | | _____ |

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**MEDICAL HISTORY:**

| HEALTH ISSUES | YOU? | FAMILY MEMBERS? | WHICH FAMILY MEMBER? |
|---|---|---|---|
| ABNORMAL UTERINE BLEEDING | YES NO | YES NO | |
| ANEMIA | YES NO | YES NO | |
| BLOOD DISORDERS | YES NO | YES NO | |
| BLOOD TRANSFUSIONS | YES NO | YES NO | |
| BREAST DISEASE | YES NO | YES NO | |
| BRONCHIAL ASTHMA | YES NO | YES NO | |
| CANCER | YES NO | YES NO | |
| CHRONIC HYPERTENSION | YES NO | YES NO | |
| DIABETES | YES NO | YES NO | |
| EENT (EAR, EYES, NOSE, THROAT) | YES NO | YES NO | |
| ENDOCRINE DISORDERS | YES NO | YES NO | |
| GALLBLADDER DISEASE | YES NO | YES NO | |
| GENETIC DISEASE | YES NO | YES NO | |
| HEART DISEASE | YES NO | YES NO | |
| HEMOGLOBINOPATHY | YES NO | YES NO | |
| HEPATITIS | YES NO | YES NO | |
| HIGH CHOLESTEROL | YES NO | YES NO | |
| INFERTILITY | YES NO | YES NO | |
| IMMUNE SYSTEM DISORDERS | YES NO | YES NO | |
| INTESTINAL DISORDERS | YES NO | YES NO | |
| KIDNEY DISORDERS | YES NO | YES NO | |
| LIVER DISEASE | YES NO | YES NO | |
| LUNG DISEASE | YES NO | YES NO | |
| MULTIPLE BIRTHS | YES NO | YES NO | |
| NEUROLOGIC DISORDERS | YES NO | YES NO | |
| ORTHOPEDIC | YES NO | YES NO | |
| PULMONARY EMBOLISM | YES NO | YES NO | |
| DEEP VEIN THROMBOSIS | YES NO | YES NO | |
| PSYCHIATRIC DISORDERS | YES NO | YES NO | |
| STROKES | YES NO | YES NO | |
| TUBERCULOSIS | YES NO | YES NO | |
| OTHER | YES NO | YES NO | |

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____