Tepeyac OB/GYN
Something More Than Medicine™

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MEDICAL HISTORY

Date: _______________

Name: Date of Birth: Age:

MENSTRUAL HISTORY

First day of last period:
___ / ___ / _______
❒ Regular ❒ Irregular
❒ Menopause ❒ Hysterectomy
Age at onset:
Days from start to start:
Days of bleeding:
pads used daily:
tampons used daily:
Non-menstrual bleeding: Y/N
Severe menstrual pain: Y/N

PREGNANCY HISTORY (include term, pre-term, miscarriage & abortion)

Name	DOB	Weeks pregnant	Type of delivery	Anesthesia	Hours of labor	Place of birth	Weight	Complications & Health

Family Planning method: ❒ Natural Family Planning ❒ Oral contraceptives ❒ IUD ❒ Condoms
❒ Female sterilization ❒ Male sterilization ❒ None ❒ N/A ❒ Other: ___________

GYNECOLOGIC HISTORY

Last Pap Smear date: _________
❒ Normal ❒ Abnormal
Last Mammogram: _________
❒ Normal ❒ Abnormal
Last DEXA scan: _________
❒ Normal ❒ Abnormal
Last colonoscopy: _________
❒ Normal ❒ Abnormal

Check if you have **ever** had one of the following conditions:

❒ Abnormal Pap smear
❒ Breast Cancer
❒ Breast Lump
❒ Chlamydia
❒ Ectopic pregnancy
❒ Endometriosis
❒ Gonorrhea
❒ Herpes
❒ HIV
❒ Osteoporosis/Osteopenia
❒ Ovarian Cyst
❒ Polycystic Ovarian Syndrome
❒ Pelvic Inflammatory Disease
❒ STI/STD (other)

PERSONAL MEDICAL HISTORY (check if you have had any of the following)

❒ Allergies (seasonal)
❒ Anemia
❒ Anxiety
❒ Asthma
❒ Blood clot (DVT or PE)
❒ Cancer (specify)
____
❒ COPD
❒ Depression
❒ Diabetes, Type 1
❒ Diabetes, Type 2
❒ Ear disease/impairment
❒ Eating disorder
❒ Eye disease/impairment
❒ GERD/Reflux

❒ Head injury/concussion
❒ Heart disease
  ❒ Coronary artery disease
  ❒ Heart attack
  ❒ Heart murmur
❒ Hepatitis
❒ High cholesterol
❒ High blood pressure
❒ Kidney disease
  ❒ Kidney infection
  ❒ Kidney stones
  ❒ Kidney failure
❒ Lyme disease
❒ Meningitis

❒ Migraines, with aura
❒ Migraines, without aura
❒ Peptic ulcer
❒ Pneumonia
❒ Rheumatic fever
❒ Rheumatoid arthritis
❒ Skin disease
❒ Stroke
❒ Thyroid disease
  ❒ Hyperthyroidism
  ❒ Hypothyroidism
❒ Trauma (physical or emotional)
❒ Tuberculosis
❒ Other:
____

CURRENT MEDICATIONS	ALLERGIES	PREVIOUS SURGERY & YEAR

FAMILY HISTORY

	Age & Medical conditions		Age & Medical conditions
Father		Children 1	
Mother		2	
Siblings 1		3	
2		4	
3		5	
4		6	
5		7	

Check & write **who** in your family has:

- ❐ Cancer
  - ❐ Breast
  - ❐ Endometrial
  - ❐ Ovarian
  - ❐ Colon
- ❐ Diabetes
- ❐ Heart disease
- ❐ High blood pressure
- ❐ DVT/PE
- ❐ Stroke
- ❐ Epilepsy
- ❐ Thyroid Disease
- ❐ Osteoporosis

SOCIAL HISTORY

Tobacco use? Y/N # Cigarettes daily: ______	Do you exercise regularly? Y/N Do you eat dairy or take calcium? Y/N
Alcohol use? Y/N # beverages weekly: ______	Occupation: Religion:
Sexually active: Current / Past / Never	Marital Status:

Are you currently experiencing any of the following symptoms?

CONSTITUTIONAL:
- ❐ Fatigue
- ❐ Fever
- ❐ Weight Gain
- ❐ Weight Loss

HEENT:
- ❐ Change in hearing
- ❐ Nose bleeds
- ❐ Sore throat
- ❐ Worsening vision

RESPIRATORY:
- ❐ Cough – productive or dry
- ❐ Shortness of Breath
- ❐ Wheezing

CARDIOVASCULAR:
- ❐ Chest Pain
- ❐ Leg or ankle swelling
- ❐ Palpitations

BREAST:
- ❐ Breast Lump/Mass
- ❐ Breast Pain
- ❐ Nipple Discharge

GASTROINTESTINAL:
- ❐ Constipation
- ❐ Dark/bloody stools
- ❐ Diarrhea
- ❐ Nausea/Vomiting

REPRODUCTIVE
- ❐ Painful Intercourse
- ❐ Vaginal discharge
- ❐ Vaginal itching/burning

URINARY:
- ❐ Painful Urination
- ❐ Blood in Urine
- ❐ Urinary frequency
- ❐ Loss of urine with cough/sneeze

MUSCULOSKELETAL:
- ❐ Back Pain
- ❐ Joint Pain, Stiffness, Swelling
- ❐ Weakness

NEUROLOGIC:
- ❐ Headaches (new onset)
- ❐ Memory Loss
- ❐ Numbness
- ❐ Tremors

PSYCHIATRIC:
- ❐ Anxiety
- ❐ Depression
- ❐ Insomnia
- ❐ PMS/Mood Swings

ENDOCRINE/HORMONAL:
- ❐ Excessive Thirst
- ❐ Hot flashes, night sweats
- ❐ Hot/Cold Intolerance

HEMATOLOGIC/LYMPHATIC:
- ❐ Easy Bruising
- ❐ Swollen Lymph Glands/Nodes

SKIN:
- ❐ Dry skin
- ❐ Rash
- ❐ New/changing skin lesion
- ❐ Hair loss
- ❐ Excessive body/facial hair