Woman to Woman Gynecology
A-All Women Care

3599 South Eastern Avenue
Las Vegas, NV, 89169 702-531-5400
www.lvgyn.com

MEDICAL HISTORY FORM

Name:____________________________Age:________________Birth date:________________________

When was your last period? __________ Was it normal? Y N

Did you do a pregnancy test? Y N

How many times have you been pregnant? ____

How many children do you have? ____

How many vaginal deliveries?____

How many C sections? ____

Did you have any complications with your previous pregnancies?	Y	N
High blood pressure?	Y	N
Severe bleeding requiring transfusions?	Y	N
Diabetes?	Y	N
Infections?	Y	N
Blood clots in the legs or lungs?	Y	N
Ectopic / Tubal pregnancy	Y	N
Do you have any medical problems?	Y	N
Problems of the thyroid gland ?	Y	N
Asthma?	Y	N
Blood clotting problems	Y	N
Heart problems (murmurs, irregular rhythm)	Y	N
Liver disease	Y	N
Ulcers	Y	N
Ovarian Cysts	Y	N
Abdominal surgery	Y	N
Pelvic infections (Gonorrhea, Chlamydia)	Y	N

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Fibroids Y N

Abnormal Pap smear (HPV infection) Y N

Have you ever had any of these:

C/Section Y N

Appendix removed Y N

Conization of the cervix for dysplasia Y N

Freezing/Laser treatment of cervix Y N

Fibroids removed Y N

Infertility surgery Y N

Ectopic/ Tubal pregnancy, surgery Y N

Are there any other medical problems you would like to tell us about?

____

____

Do you take any medications? Y N

Which ones? Include any medications prescribed and over the counter

1.____________________ 2.________________________ 3.______________________________

Do you use any street drugs? Y N

Which ones?
____

When did you use last? ____

Allergies to any medications or iodine? Y N

What is the name of the medication you are allergic to?___________________________________

What happens when you have an allergic reaction? _______________________________________

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When was your last pap smear test?____

Are you interested in having evaluation for sexually transmitted diseases?	Y	N
Are you interested in having the HPV vaccine?	Y	N

What kind of birth control would you like after your visit?

Birth control pills	Y	N
Nuva ring	Y	N
Patch	Y	N
Depo Provera shot	Y	N
IUD	Y	N
Diaphragm	Y	N
Condoms	Y	N
Tubal ligation	Y	N
Hysteroscopic tubal occlusion (newest method without incision)	Y	N

I have answered all the questions truthfully and I have not withheld any information that might affect my medical care.

Patient name and signature: Date:

____

Reviewed by the doctor: Date:

____