

Fertility & Midwifery Care Center



Patient Health History

Patient Name: _____ Age: _____ DOB: _____

Family Doctor: _____ Referred By: _____

Reason for visit: _____

Past Medical History

CONDITION	CURRENT	HISTORY	NO	CONDITION	CURRENT	HISTORY	NO
Abnormal PAP Smear				Herpes			
Anemia				Hypertension			
Anesthesia Complication				Infertility			
Anxiety				Kidney Stone			
Asthma				Liver Disease			
Blood Clots in Leg or Lungs				Lupus			
Blood Transfusion				Migraine			
Breast Disorder				Miscarriage			
Cancer of the Breast				MTHFR			
Cancer , other				Mitral Valve Prolapse			
Cardiovascular Disease				Pelvic Inflammatory Disease			
Depression				PCOS			
Diabetes				Seizures/Convulsions			
Endometriosis				Sexually Transmitted Diseases, STD's			
Epilepsy				Stroke			
Factor 5				Thyroid Disorder			
Fibromyalgia				Tuberculosis			
Heart Murmur				Ulcer			
Date of Last Pap Smear: / /		Normal	Abnormal	Date of Last Mammogram: / /		Normal	Abnormal
Date of Last Dexa Scan: / /		Normal	Abnormal	Date of Last Colonoscopy: / /		Normal	Abnormal
Other:							

Operations / Surgeries

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
1)		4)	
2)		5)	
3)		6)	

Medications

(Include prescriptions, over the counter, herbals & vitamins)

MEDICATION	DOSAGE	PRESCRIBING PHYSICIAN
1)		
2)		
3)		
4)		
5)		

SEE BACK

Medication Allergies

MEDICATION	REACTION
1)	
2)	
3)	

Family Medical History

(Do any of your children, siblings, or parents have any of the following?)

ILLNESS	YES	RELATIONSHIP	ILLNESS	YES	RELATIONSHIP
None			Cardiovascular Disease		
Adopted			Depression		
Blood Clot in Legs or Lungs			Diabetes		
Cancer, Breast			Hypertension		
Cancer, Colon			Osteoporosis		
Cancer, Ovarian			Polyp – anal/rectal/colon		
Cancer, Uterine			Stroke		
Cancer, Other			Thyroid Disorder		

Genetic History / Screening

(Self, partner, or other family member)

CONDITION	YES	RELATIONSHIP	CONDITION	YES	RELATIONSHIP
Cats – do you have exposure?			Diabetes – self only		
Chickenpox			Down Syndrome		
Congenital Heart Defect			Infertility		
Cystic Fibrosis			Rh Sensitized		
DES Exposure			Sickle Cell Anemia		

REPRODUCTIVE HISTORY

Age of first menses:	Cycle Interval (Number of days from start to start):
Menses duration (Number of days of bleeding):	Flow (circle): Light Medium Heavy
Number of Tampons per day:	Number of Pads per day:
Last Menstrual Period (date): / /	Certain of LMP date? (circle) YES NO
Menopause Status (circle): Pre Peri Post	Age at Menopause:
Method of Birth Control	Clots (circle): YES NO
Breakthrough bleeding (circle): YES NO	On HRT (circle) YES NO

Pregnancy History

Total Pregnancies: _____ / Full Term: _____ / Preterm: _____ / Miscarriage: _____ / Abortion: _____ / Ectopic: _____ / Multiple: _____ / Living: _____

DATE	GESTATIONAL AGE	HOURS IN LABOR	BIRTH WEIGHT	SEX	TYPE OF DELIVERY	ANESTHESIA	EARLY LABOR?	COMMENTS/ COMPLICATIONS	HOSPITAL

Social History

Marital Status (circle): Divorced Married Single Widowed Spouse/Partner Name: _____
Occupation: _____
Alcohol: _____ Never _____ Current _____ Former _____ Amount per week
Drugs: _____ Never _____ Current _____ Former _____ Type
Smoking: _____ Never _____ Current _____ Former _____ Amount per day
Amount of Exercise?: Active Heavy Medium Minimal None (Sedentary)