BELLINGHAM **Patient Name:** ____________________________ **Date:** _________

OB/GYN

PAST MEDICAL HISTORY

Please check the applicable boxes to indicate a disorder you have or have had in the past

CANCER

Breast	
Cervical	
Colon	
Endometrial/Uterine	
Lung	
Ovary	
Skin	
Vaginal	
Vulvar	
Other	

CARDIAC

Arrhythmia	
Heart Disease	
Heart Murmur/ Mitral Valve Prolapse	
High Blood Pressure	
High Cholesterol	
Other	

DERMATOLOGY

Acne	
Eczema/Psoriasis	
Other	

ENT

Hearing Loss	
Seasonal Allergies/ Allergic Rhinitis	
Other	

ENDOCRINOLOGY

Diabetes	
Glucose Intolerance/ Insulin Resistance	
History of Gestational Diabetes	
Hyperthyroidism	
Hypothyroidism	
Osteopenia	
Osteoporosis	
Prolactinoma	
Vitamin Deficiency	
Other	

EYES

Glaucoma	
Vision Loss/Macular Degeneration	
Other	

GI

Colon Polyps	
Crohn's/ Ulcerative Colitis	
Gallbladder Disease	
Hemorrhoids	
Irritable Bowel Syndrome	
Liver Disease/ Hepatitis	
Reflex/ Ulcers	
Other	

Gynecology

Dysplasia	
Endometriosis	
Fibroids	
Infertility	
PCOS	
Other	

HEMATOLOGY

Anemia	
Bleeding Disorder	
Clotting Disorder/ Factor V Leiden	
Blood Transfusion	
Deep Vein Thrombosis/Pulmonary Embolism	
Other	

INFECTIOUS DISEASES

Tuberculosis/ Positive PPD	
Chicken Pox/ Shingles	
HIV	
MRSA	
Other	

NEPHROLOGY

Renal Disease	

NEUROLOGY

Dementia	
Headaches/Migraines	
Multiple Sclerosis	
Seizures/Epilepsy	
Stroke/TIA	
Other	

ORTHOPEDICS

Arthritis	
Chronic Back Pain	
Fractures	
Other	

PSYCHOLOGY

ADD	
Anxiety Disorder	
Depression	
Eating Disorder	
PMS/PMDD	
Other	

PULMONARY

Asthma	
COPD/Emphysema	
Sleep Apnea	
Other	

RHEUMATOLOGY

Arthritis	
Autoimmune Disease	
Fibromyalgia/Chronic Pain	
Other	

UROLOGY

Stones	
Urinary Incontinence	
Other	

GYNECOLOGIC HISTORY:

Date of last menstrual period	
Date of last mammogram	
Date of last colonoscopy	
Date of last DEXA (Bone Density)	
Date of last pelvic ultrasound	
Date of last pap smear	
Date of last HPV test	
HPV Vaccination	**YES NO**
History of abnormal pap smear	**YES NO**
History of cervical dysplasia	**YES NO**
Sexually active	**YES NO**
Age at coitarche (first intercourse)	
Total lifetime sexual partners	
Sexual Preference	**Males Females Both**
History of Sexually Transmitted Infection	**YES NO Please Specify:**
Current birth control method	
Age at menarche (first period)	
Age at menopause (if applicable)	
Post-menopausal hormone use	**YES NO**
History of Endometriosis	**YES NO**
History of Infertility	**YES NO**
History of Recurrent Ovarian Cysts	**YES NO**
History of Dysmenorrhea (Painful Menses)	**YES NO Please Specify:**
Menstrual cycle length (days)	

FAMILY HISTORY:

Please indicate any 1st or 2nd degree relatives* who have been diagnosed with a disorder and include if they are maternal (mother's side) or paternal (father's side) relatives. (*Grandparents, Parents, Siblings, Uncles, Aunts, or Children.)

Breast Cancer	
Cervical Cancer	
Colon Cancer	
Endometrial/Uterine Cancer	
Ovarian Cancer	
Cardiac Disorder (Please specify)	
Thyroid Disorder (Please specify)	
Diabetes Mellitus	
Osteoporosis	
Bleeding Disorder (Please specify)	
Neurological Disorder (Please specify)	