FEMI-CARE SURGERY CENTER
MEDICAL HISTORY

Patient Name _____

Have you had a positive pregnancy test? YES NO N/A
Where? _____

How did you find out about us? _____

What is your gynecologist's name? _____

Are you in good health today? YES NO

Circle the number of each of the following you have or ever had:

1. Frequent Headaches
2. Thyroid problems
3. Heart murmur/Problem
4. Rheumatic fever
5. Chest pains
6. Shortness of breath
7. Asthma/Hay fever
8. Allergies/Allergic reaction
9. Breast lump/tumor
10. Stomach pain/Ulcers
11. Hepatitis/Jaundice
12. Gall Bladder/Appendicitis
13. Disease/Surgery of female organs
14. Vaginal infection
15. Gonorrhea
16. Syphilis
17. Pelvic inflammatory disease
18. Do you smoke? NO YES, how much _____ for how long _____
19. Do you use elicit drugs? NO YES
20. Do you use IV drugs? NO YES
21. Bladder/Kidney Infections
22. Blood Clot/Phlebitis
23. Swollen feet and ankles
24. Epilepsy/Seizures/Fits/Convulsions
25. Anemia/Low Iron
26. Fainting/Dizzy spells
27. Diabetes (sugar)
28. Bleeding tendency
29. Blood transfusions
30. High blood pressure
31. Sickle cell disease
32. Cancer
33. Been a hospital patient
34. Had any surgery
35. Counseling for emotional problems
36. Other problems

Have you ever used any of the following medications?

Aspirin/Tylenol	NO	YES	Antibiotics (Penicillin. Tetracycline)	NO	YES
Codeine/Demerol	NO	YES	Tranquilizers/Sedatives	NO	YES
Sulfa	NO	YES	Novocain/Local Anesthetics	NO	YES

Other: _____

Have you ever had an allergic reaction to ANY medication? _____

What medications or drugs have you taken today? _____

Are you wearing contact lenses today? NO YES, Hard or Soft

FAMILY HISTORY: Have any of your relatives had cancer, diabetes, TB, allergies, epilepsy, heart problems, stroke, high blood pressure?

WHO	WHAT	WHO	WHAT
_____		_____	
_____		_____	
_____		_____	

see other side

MENSTRUAL HISTORY

Began at age _____

Period comes every _____ days

Days of flow _____

Amount of flow: Scant Moderate Heavy

Cramps: None Mild Moderate Severe

Occur: Before During After your period

Relieved by: _____

First day of last period _____

Was your last period on time? YES NO
If no, was it Late? Early? Shorter?

Was the flow Lighter Heavier Spotting Normal

INTERNAL/PELVIC EXAMINATIONS

Ever had one? YES NO

Last exam date? _____

What was found? _____

Last pap smear? _____

To your knowledge, did your mother ever take Hormones (DES) while she was pregnant with you? _____

CONTRACEPTIVE HISTORY

Have you ever used any of the following methods of birth control?

PILL _____ _____
Type Problem

IUD _____ _____
Type Problem

DIAPHRAGM

_____ _____
Type Problem

FOAM/CONDOMS _____
Problem

RHYTHM/WITHDRAWAL _____

STERILIZATION _____

Were you using a birth control method when you became pregnant?

Do you plan to use birth control after today?
If so, what? _____

PREGNANCY

How many times have you been pregnant before this time?

Live Births _____ Still births _____

Miscarriage _____ Abortions _____

Premature Labor Rh Problems

Malformed infant C-Section

COMPLICATIONS OF PREGNANCY

Toxemia Ectopic/Tubal Pregnancy Twins