

Spring Ob/Gyn, PC

135 Spring Street
New York, NY 10012
212-219-1187

Heidi Flagg, MD
Brina Maldonado, MD
Cara Stanko Dodson, MD
Danielle Feldman, MD
Elizabeth Rodgers, MD
Linda Cho, MD
Bonnie Yim, CNM
Lauren Lese, CNM

MEDICAL HISTORY FORM

Name: _____ Date: _____
(Last name, First name, Middle initial)

Please answer these questions about your previous and current health. Your health care provider will review these with you.

Reason for visit:

Referred by:

--

Who is your General Physician? (internist, family practitioner, PCP):

--

Past Gynecological History:

Please check off any conditions that you have had and give dates if appropriate.

Gynecological Illness	Yes	No	Date	Gynecological Illness	Yes	No	Date
Pelvic Inflammatory Disease	<input type="checkbox"/>	<input type="checkbox"/>		Human Papilloma Virus (HPV)	<input type="checkbox"/>	<input type="checkbox"/>	
Ovarian Cyst	<input type="checkbox"/>	<input type="checkbox"/>		Herpes	<input type="checkbox"/>	<input type="checkbox"/>	
Uterine Fibroids	<input type="checkbox"/>	<input type="checkbox"/>		Other Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>	
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>		Abnormal PAP Smears	<input type="checkbox"/>	<input type="checkbox"/>	
Breast Disease	<input type="checkbox"/>	<input type="checkbox"/>		Other:	<input type="checkbox"/>	<input type="checkbox"/>	
Fertility Problems	<input type="checkbox"/>	<input type="checkbox"/>		Other:	<input type="checkbox"/>	<input type="checkbox"/>	

Menstrual History:

Age at first menses:	If menopausal, age at last menses:
Usual interval between periods <small>(1st day to 1st day):</small>	
Usual days of bleeding with each period:	
Cramping with period? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Need for pain medication <small>(please list):</small>	
Bleeding between periods? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you experience PMS? <input type="checkbox"/> Yes <input type="checkbox"/> No

Miscarriage(s): please list date(s)

--

Termination(s) of pregnancy: please list date(s)

--

Name: _____ Date: _____
(Last name, First name, Middle initial)

Use of contraception: *(please check all that apply, past and/or present)*

Oral birth control pills	<input type="checkbox"/>		IUD	<input type="checkbox"/>	
Cervical cap	<input type="checkbox"/>		Norplant	<input type="checkbox"/>	
Diaphragm	<input type="checkbox"/>		Depo-Provera	<input type="checkbox"/>	
Condoms	<input type="checkbox"/>		Other:	<input type="checkbox"/>	

Sexual history/orientation: *please write in (or speak to your provider) about any information or concerns you would like for her to know*

Have you ever experienced rape, incest, domestic violence or sexual abuse? Yes No

Pregnancies:

Year	Type of delivery	Birth weight of infant	Complications

Past surgical procedures: *(including non-gynecologic)*

Year	Procedure	Complications

Past medical problems: *Please check any that you have had and give dates if appropriate.*

Past medical problem	Yes	No	Date	Past medical problem	Yes	No	Date
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>		Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Mitral Valve Prolapsed	<input type="checkbox"/>	<input type="checkbox"/>		Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Eating Disorder:	<input type="checkbox"/>	<input type="checkbox"/>		Gastrointestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>		High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>		Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>		Other Psychological Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>		Other:	<input type="checkbox"/>	<input type="checkbox"/>	
Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>		Other:	<input type="checkbox"/>	<input type="checkbox"/>	

Name: _____ Date: _____
(Last name, First name, Middle initial)

Medications: Please list any prescription or over-the-counter medications r vitamins that you are taking.

Medication:	Dosage:

Allergies to medications: Please check if you have any of the listed allergies. Please list any other medications you are allergic to.

Penicillin	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	Other	<input type="checkbox"/>
Sulfa Medications	<input type="checkbox"/>	Latex	<input type="checkbox"/>	Other	<input type="checkbox"/>

Diet/Habits:

Are you on a restricted diet? (i.e. vegetarian, low cholesterol, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, identify type of restricted diet:		
Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How many packs per day?		
How many alcoholic drinks per week?		
Other drug use? (specify)		

Exercise:

Do you engage in regular exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, indicate type of exercise and frequency.

Family history: Does/Did any family member have any of the following? Please check appropriate responses.

Breast cancer	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
Colon cancer	<input type="checkbox"/>	Heart disease (prior to age 65 [women] and 55 [men])	<input type="checkbox"/>
Ovarian cancer	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>
Uterine cancer	<input type="checkbox"/>	Bleeding disorders	<input type="checkbox"/>

Please list any other health information that you would like to discuss:
