

Spring Ob/Gyn

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MEDICAL HISTORY FORM

Name: _____ Date: _____

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				Human Papilloma Virus (HPV)			
Ovarian Cyst				Herpes			
Uterine Fibroids				Other Sexually Transmitted Diseases			
Endometriosis				Abnormal PAP Smears			
Breast Disease				Other:			
Fertility Problems				Other:			

Menstrual History:

Age at first Menses:	If Menopausal, age at last menses:
Usual Interval Between Periods (1st day to 1st day):	
Usual Days of Bleeding with each Period:	
Cramping with Period:	
Need for Pain Medication (please list):	
Bleeding Between Periods:	Do you experience PMS?

Miscarriage(s):

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

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Name: _____ Date: _____

Use of Contraception: *(please list present and past)*

Oral Birth Control Pills			IUD		
Cervical Cap			Norplant		
Diaphragm			Depo-provera		
Condoms			Other:		

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?

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				Osteoporosis			
Asthma				Hepatitis			
Epilepsy				High Blood Pressure			
Heart Disease				Bleeding Disorder			
Mitral Valve Prolapse				Anemia			
Tuberculosis				Diabetes			
Eating Disorder:				Gastrointestinal Problems			
Bulimia				High Cholesterol			
Anorexia				Depression			
Kidney Infection				Other Psychological Problems			
Thyroid Abnormalities				Other:			
Seasonal Allergies				Other:			

Name: _____ Date: _____

Medications: Please List any Prescription or Over-The Counter Medications or 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.)	
Do you smoke?	How many packs per day?
How many alcoholic drinks per week?	
Other Drug use?	

Exercise:

Do you engage in regular exercise?	

Family History: Do/Did any Family members 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:
