Medical History

Name: ______________________________ Date of Birth: ______________ Date: ______________

Reason for visit: ____

____

Surgical History: Please list all surgeries with dates: ______________________

______________________ ______________________

______________________ ______________________

Medication: Are you currently taking any medication(s)? _____Yes _____No

List all medications you are currently taking, including over-the-counter medications, vitamins and herbal remedies:

______________________ ______________________

______________________ ______________________

______________________ ______________________

Reason for taking current medication:

____

____

List any allergies to medications: ___ No Known Allergies

______________________ ______________________

______________________ ______________________

LATEX Allergy? _____Yes _____No

GYN History:

Are you sexually active? __ Yes __ No

Sexual preference __ Male __ Female __ Both

New Partners? __ Yes __ No

Number of lifetime partners: __________

Method of Birth Control:

__ Condoms
__ Pills
__ Patch
__ IUD
__ Implanon
__ Vaginal Ring
__ Tubal Ligation
__ Depo Provera
__ Partner with Vasectomy
__ Natural Family Planning
__ Other ______________
__ None