MAY-GRANT
OBSTETRICS | GYNECOLOGY

PERSONAL HEATH HISTORY

Name: _____ **Date:** _____

Date of Birth: _____

YOUR MEDICAL HISTORY (Do YOU have any of the following?)
additional room on back if necessary

YES	
	Asthma/Lung Disease
	Cancer
	Breast Disease
	Kidney Problems
	Diabetes (age of diagnosis)
	Liver/Gallbladder Disease
	Heart Disease
	High Blood Pressure
	High Cholesterol
	Phlebitis or Blood Clots
	SeizuresEpilepsy

YES	
	Thyroid Problems
	Depression
	Bowel Problems
	HIV/AIDS
	Anemia
	Hepatitis
	Osteoporosis/Fractures
	Blood Transfusion
	Allergic to Latex
	Allergic to Iodine

History of abnormal PAP(s) (describe when an any treatment: _____

Have you ever had pelvic infections: _____Yes _____No (If yes, please describe):_____

_____

Do you have a history of infertility? (Please explain):_____

_____

Have you been diagnosed with, or treated for:

_____ Herpes _____ Gonorrhea _____ Chlamydia _____ Genital Warts/HPV

_____ Trichomonas _____ Bacterial Vaginosis _____ Syphilis

HOSPITALIZATIONS/SURGERIES (other than childbirth)	YEAR

CURRENT MEDICATIONS	ALLERGIES

MAY-GRANT IS A LEADING OBGYN PROVIDER IN LANCASTER AND LEBANON COUNTY
AND A PROUD MEMBER OF

U.S. WOMEN'S HEALTH ALLIANCE

Your FAMILY Medical History

_____ Both parents are alive and well

Mother: _____ Living _____ Deceased Age/Cause: _____

Father: _____ Living _____ Deceased Age/Cause: _____

Siblings: Number living _____ Number Deceased _____ Cause(s): _____

Yes	Illness/Disease	Relationship (Maternal or Paternal)
	Breast Cancer	
	Uterine Cancer	
	Cervical Cancer	
	Ovarian Cancer	
	Colon Cancer	
	Other Cancer	
	High Blood Pressure	
	Heart Attack(s)	
	Depression	

Yes	Illness/Disease	Relationship (Maternal or Paternal)
	Stroke	
	Blood Clotting Disorder	
	Diabetes	
	Osteoporosis	
	Birth Defects	
	Alcoholism/Addiction	
	Sickle Cell, Thalassemia	
	Tay Sachs	
	Other genetic disease	

Gynecologic History

How old were you at your first menstrual period? _____

How often do you get periods? (from the first day of one to the first day of the next) _____

How many days do you bleed? _____ Heavy _____ Moderate_____Light_____

What do you use for birth control? _____ or Tubal or Vasectomy (circle which)

Obstetric History

(List all pregnancies, including ***miscarriages, abortions, stillbirths, and live births***)

Date	Type of Pregnancy (C-section, vaginal, misc, abortion)	Complications/Problems	Birth Weight	Child's Name

Social History

	YES	
Do you smoke?		If yes, how many cigarettes per day?
Do you use alcohol?		If yes, how much and how often?
Do you use street drugs?		If yes, what kind?
Have you been a victim of sexual abuse?		If yes, when?
Have you been a victim of physical abuse?		If yes, when?
Do you feel safe in your current life situation?		If no, please explain:
Do you wear seat belts?		
Do you exercise?		

What is your occupation? _____

What does your spouse/partner do? _____

Do you have a sexual partner? _____ Yes _____ No

Monogamous relationship? _____ Yes _____ No

Is your sexual partner: _____ Male _____ Female ____ Both

Lifetime number of sexual partners: _____ (this can affect risk for abnormal PAPs)