BEDFORD Women's Care ASSOCIATES, P.A.

First Name:	Last Name:	DOB:
Work Status: Full time Part time Unemployed	**Occupation:**	

Medical History

Check all that apply. Have you ever had:

☐	Asthma or breathing problems	Details:	Month/Year Diagnosed:
☐	Pneumonia or Tuberculosis (Circle)	Month/Year Diagnosed:	
☐	Seizures or Epilepsy	Details:	Month/Year Diagnosed:
☐	Migraine Headaches	Month/Year Diagnosed:	
☐	Frequent non-migraine headaches	Date of onset:	Frequency:
☐	Neurological Disorder	Details:	Month/Year Diagnosed:
☐	Visual/Hearing impairment	Details:	Month/Year Diagnosed:
☐	High Blood Pressure	Month/Year Diagnosed:	
☐	High Cholesterol	Month/Year Diagnosed:	
☐	Heart Murmur	Month/Year Diagnosed:	
☐	Mitral Valve Prolapse	Month/Year Diagnosed:	
☐	Heart or cardiac problems	Details:	Month/Year Diagnosed:
☐	Varicose Veins or Circulatory problems	Details:	Year of Onset:
☐	Urinary Tract or Kidney infection/stones	Month/Year Diagnosed:	
☐	Urinary Incontinence	Details:	Symptom onset:
☐	Thyroid Disorder or Goiter	Details:	Month/Year Diagnosed:
☐	Diabetes or Endocrine Disorder (circle)	Details:	Month/Year Diagnosed:
☐	Gallbladder Disease/Stones	Details:	Month/Year Diagnosed:
☐	Refulux/Digestive/Abdominal Concerns	Details:	Month/Year Diagnosed:
☐	Hemorrhoids	Details:	Month/Year Diagnosed:
☐	Liver Disease	Details:	Month/Year Diagnosed:
☐	CANCER OF ANY TYPE	Details:	Month/Year Diagnosed:
☐	Anemia	Month/Year Diagnosed:	
☐	Blood Disorder or Clotting Disorder (circle)	Details:	Month/Year Diagnosed:
☐	Skin Disease	Details:	Month/Year Diagnosed:
☐	Chicken Pox	Month/Year Diagnosed:	
☐	Arthritis or Musculoskeletal Disorders	Details:	Month/Year Diagnosed:
☐	Osteoporosis/Osteopenia	Month/Year Diagnosed:	
☐	Depression	Month/Year Diagnosed:	
☐	Anxiety	Month/Year Diagnosed:	
☐	Psychological Disorder	Month/Year Diagnosed:	
☐	Anorexia/Bulemia	Details:	Month/Year Diagnosed:

Medical History Continued

Check all that apply. Have you ever had:

☐ Ovarian Cysts	Details:	Month/Year Diagnosed:
☐ Abnormal Pap Smears	Details:	Month/Year Diagnosed:
☐ Gynecological Conditions	Details:	Month/Year Diagnosed:
☐ OTHER:	Details:	Month/Year Diagnosed:

Allergies:

Are you allergic to latex? NO YES Reaction:

Are you allergic to any medications or foods? NO YES

Medication/Reaction: Medication/Reaction:

Medication/Reaction: Medication/Reaction:

Current Medications (Including any over the counter or herbal supplements):

Medication/Dose:	Medication/Dose:
Medication/Dose:	Medication/Dose:
Medicaton/Dose:	Medication/Dose:
Medicaton/Dose:	Medicaton/Dose:

SURGICAL HISTORY

Have you ever had any surgery - minor or major? NO YES

Surgery:	Date:
Surgery:	Date:
Surgery:	Date:
Surgery:	Date:
Surgery:	Date:
Surgery:	Date:

Have you ever had any complications after anesthesia? NO YES Details:

Gynelogical/Reproductive History:

Age of first menstrual period:	Date of your last menstrual period (LMP):
Number of days between menses:	Certainty of LMP date (circle): Sure Unsure
Menses duration:	Breakthrough bleeding(circle)? NO YES
Flow (circle): Light Medium Heavy	Clots (Circle)? NO YES
Number of tampons used per cycle:	Cramps (circle)? NO YES
Number of Pads used per cycle:	Birth Control Method:

Are you planning a pregnancy in the next 6-12 months? NO YES

Are you sexually active? NO YES

Have you ever had an STD?: ___Chlamydia___Gonorrhea___Syphilis___Genital Warts___Herpes__Trichomoniasis__PID

Do you have a history of herpes exposure?

Number of Lifetime sexual partnners: (circle) More than 5 Less than 5 One

Age of first sexual intercourse:

Do you perform a monthly self breast exam? NO YES

Did your mother take DES while pregnant with you? NO YES

Have you ever had any trouble getting pregnant? NO YES Details:

Obstetrical History - Previous pregnancies

Date m/d/y	Type: Miscarriage/Ectopic Abortions/Stillborns Vaginal/C-Section	Sex Weight Condition of baby	Hours of Labor	Type Anesthesia	Months Breast Fed	Place of Delivery	Complications

Social History

Marital status: Single Living Together Engaged Married

How is your partner/spouses health? Health Concern(s):

What is your sexual preference: Heterosexual Homosexual Bisexual

Have you ever smoked?

- ☐ NO
- ☐ Yes/Currently: How many cigarettes do you smoke a day?
  What age did you start smoking?
- ☐ Yes/History: For how long did you smoke?
  How much did you smoke per day during that time?

Do you consume alcoholic beverages? NO YES How many beverage per week/month?

Do you drink caffeine? NO YES How many beverages per day?

Do you use recreational/street drugs? NO YES What drugs/how often?

Have you ever had a legal or illegal drug abuse problem?

Do you exercise regularly? NO YES If Yes, how often?

Do you consume dairy products? NO YES If yes, how many servings per day?

Do you wear your seatbelts? NO YES

Do you have a new sexual partner? (Circle) NO YES Decline to answer

Are you a victim of Abuse? No Yes Type: sexual physical verbal emotional

Family Medical History:

Check all that apply. Indicate which family member : Mother, Father, Sibling, Maternal/Paternal Family member

☐	Birth Defects	Details/Family Member(s):
☐	High Blood Pressure	Details/Family Member(s):
☐	Stroke	Details/Family Member(s):
☐	Heart Attack or Heart Disease	Details/Family Member(s):
☐	High Cholesterol	Details/Family Member(s):
☐	Cancer	Details/Family Member(s):
☐	Thyroid Disease/Endocrine Disease	Details/Family Member(s):
☐	Diabetes	Details/Family Member(s):
☐	Seizures/Epilepsy	Details/Family Member(s):
☐	Kidney Disease	Details/Family Member(s):
☐	Mental Illness	Details/Family Member(s):
☐	Blood Disease	Details/Family Member(s):
☐	Osteoporosis	Details/Family Member(s):
☐	Twins	Details/Family Member(s):
☐	Other	Details/Family Member(s):

Is there anything else regarding your person/surgical/family history that you think we should know? NO YES

Details: