Raleigh Gynecology & Wellness, PA

PAST MEDICAL HISTORY

Chart # _____

Patient's Name: _____ Date: _____

PAST MEDICAL HISTORY (Circle if positive)

Headaches	Gonorrhea	Mental Illness
Seizures	Liver Disease	Cancer
Thyroid Disease	Chlamydia	Benign Tumors
Pneumonia	Syphilis	Mitral Valve Prolapse
Asthma	Herpes	Kidney Disease
Heart Disease	Vaginal Warts	Eating Disorder
Blood Transfusion	Abnormal Pap Smears	Breast Cancer
Anemia	Hemorrhoids	Bladder Infections
Gallstones	Infertility	Blood Clots in legs or lungs
Bowel Problems	Endometriosis	Tuberculosis
Blood Clotting Disorders	Hypertension	Diabetes

Please list all hospitalizations and surgeries including deliveries and c-sections:

DATE	SURGERY	REASON

FAMILY MEDICAL HISTORY

Please list ages of parents and children.

RELATION	AGE (if deceased, at what age, and cause of death)
Father	
Mother	
Spouse	
Your Children 1	
2	
3	
4	

Have any of your first degree relatives (father, mother, brother, sister, daughter, son) ever had any of the following? Leave blank if NO

DISEASE	RELATIVE
Cancer	
Breast	
Ovarian	
Colon	
Melanoma	
Other	
Heart Disease	
High Blood Pressure	
Diabetes	
Endometriosis	
Infertility	
Birth Defects	
Mental Illness	
Thyroid Disease	
Osteoporosis	

Signature: _____ Date: _____