

Patient's Past Medical History

Patient's Name _____ Age _____ Date _____

1. Pregnancy History

Total number of : Pregnancies _____ Live Births _____ Miscarriages _____ Children alive today _____ Other _____

Total number of types of deliveries: Vaginal _____ C-Sections _____ Vaginal births after C-Section _____

Dates of Births
& Weights of Babies: _____

2. Past Medical History:

Prior Medical Problems or illnesses: _____

Operations: _____

3. Menstrual History:

Age when first started menstrual cycles: _____ yrs. Age at onset of menopause: _____ yrs.

What menstrual problems do you have currently, if any: (Circle those applicable)

Irregular cycles / Heavy / Light / No cycles / Painful cycles / other _____

4. Medical problems present in your family? (Circle those applicable)

Diabetes, Heart Disease, High Blood Pressure, Thyroid Problems, Endometriosis, Uterine Fibroids, Other _____

Cancer of the: Lung, Breast, Colon, Uterus, Ovary, Liver, Pancreas, Brain, Bone, Other _____

Any hereditary problems or birth defects in you or your family, your husband or your husband's family? _____

5. Medications you are on now, if any: _____

6. Allergies to drugs, if any: _____

7. Immunizations (circle those you have received): Polio / Rubella / Measles / Mumps / DPT / DT / Tetanus

I hereby grant permission to **Robert L. True, M.D.** to employ such established treatments and therapy as may be deemed professionally necessary or advisable in the diagnosis and treatment of my condition or ailments. This authorization shall remain in full force and effect for this and future visits unless the consent is cancelled by my personal written notice filed with the above physician.

Patient's Signature (or guardian) _____ Date _____