Cornerstone Clinic for Women – Medical History *Page 1 of 2*

For Insurance Purposes Please Fill out in DETAIL **Today's Date: _____**

Name: _____ DOB: _____-_____-_____

Primary Care Physician: _____ Phone: _____ ❑ I do not have a primary physician

Your Email Address _____

PAST MEDICAL HISTORY: (*Check if you have ever had or been diagnosed with any of the following)*

❑ Anemia
❑ Anxiety
❑ Arthritis ❑ Rheumatoid or ❑ Osteo.
❑ Asthma
❑ Bipolar Disorder
❑ Cancer – Breast
❑ Cancer – Colon
❑ Cancer – Ovarian
❑ Cancer – Uterine
❑ Cancer – Other _____
❑ Constipation
❑ Chlamydia
❑ Chronic Lung Disease
❑ Deep Venous Thrombosis
❑ Depression
❑ Diabetes Type I or ❑ Type II
❑ Emphysema
❑ Endometriosis
❑ Epilepsy/Seizures
❑ Glaucoma
❑ Fibrocystic Breast Disease
❑ Fibromyalgia
❑ Gallstones
❑ Genital Warts
❑ Gonorrhea
❑ Heart-Mitral Valve Prolapse
❑ Heart murmur
❑ Heart-Coronary Artery Disease
❑ Hepatitis A or ❑ B or ❑ C
❑ Herpes, Genital
❑ High blood pressure
❑ High Cholesterol
❑ HIV
❑ Hyperthyroid ❑ Hypothyroid
❑ Infertility
❑ Irritable Bowel Syndrome
❑ Kidney Infection
❑ Kidney Stones
❑ Mental Illness
❑ Migraine Headaches
❑ Ovarian Cysts
❑ Overactive Bladder
❑ Pelvic Organ Prolapse
❑ Pelvic/Vaginal Pain
❑ Pneumonia
❑ Polycystic Ovaries/PCOS
❑ Post-Partum Depression
❑ Premenstrual Syndrome
❑ Pulmonary Embolism
❑ Rheumatic fever
❑ Sickle Cell Anemia or ❑ Trait
❑ Stroke
❑ Transfusions
❑ Trichomonas
❑ Tuberculosis
❑ Ulcer (Stomach)
❑ Uterine Fibroids
❑ Urinary Incontinence
❑ Yellow Jaundice
❑ Other _____

HEALTH SCREENINGS

Last Bone Density Test Where:_____ Date: _____ ❑ Normal ❑ Abnormal _____
Last Cholesterol Level Where:_____ Date: _____ ❑ Normal ❑ Abnormal _____
Last Colonoscopy Where:_____ Date: _____ ❑ Normal ❑ Abnormal _____
Last Diabetes Test Where:_____ Date: _____ ❑ Normal ❑ Abnormal _____
Last Mammogram: Where:_____ Date: _____ ❑ Normal ❑ Abnormal _____
Previous abnormal mammograms? ❑ No ❑ Yes Date: _____ Treatment:_____
Last Pap Smear: Where:_____ Date: _____ ❑ Normal ❑ Abnormal _____
Previous abnormal Pap smears? ❑ No ❑ Yes Date: _____ Treatment:_____
Last Thyroid Test Where:_____ Date: _____ ❑ Normal ❑ Abnormal _____

IMMUNIZATIONS:

Last Flu Vaccine Received Where:_____ Date: _____
Last Pneumonia Vaccine Received Where:_____ Date: _____
❑ HPV Vaccine 1 ❑ 2 ❑ 3 ❑ Where:_____ Date: _____ Date: _____ Date: _____
❑ TDAP Vaccine Where:_____ Date: _____

PAST SURGICAL HISTORY: (*Please check any that you have had and the date of surgery*)

❑ Appendectomy _____
❑ Breast _____
❑ Cesarean Section _____
❑ D&C _____
❑ Diagnostic Lap._____
❑ Gallbladder _____
❑ Heart _____
❑ Hysterectomy- Abdominal _____
❑ Hysterectomy - Vaginal _____ ❑ Laparoscopic ❑ Robotic
❑ Ovaries Removed _____ ❑ Right ❑ Left
❑ Tonsillectomy _____
❑ Tubal Ligation _____
❑ Vaginal Repair_____
❑ Uterine Ablation _____
❑ Other _____

CURRENT MEDICATIONS: (List all medications, even over the counter, vitamins, herbal remedies, etc. Include the following information regarding your medications. You may use additional pages if necessary. Also, please bring all your medications with you to your appointment.)

Medication	Strength	How Often	Prescribed By	Reason

NAME: _____ **DOB:** _____ ***Preferred Pharmacy** _____ ***Page 2 of 2***

****Pharmacy Phone number** _____ ****Pharmacy Location** _____

ALLERGIES: Please list below

Medical Allergies	Reaction	Food Allergies	Reaction	Environmental	Reaction

FAMILY HISTORY: (*Please check if any of your family members have had the following. Please add age if known.)*

	Mother	Father	Brother	Sister	Mom's Mother	Dad's Mother	Mom's Father	Dad's Father	Aunt	Uncle
Breast Cancer ❑ Cause of Death										
Colon Cancer ❑ Cause of Death										
Diabetes Type I ❑ Cause of Death										
Diabetes Type II ❑ Cause of Death										
Heart Disease/ MI ❑ Cause of Death										
High Blood Pres.										
Ovarian Cancer ❑ Cause of Death										
Stroke ❑ Cause of Death										
Uterine Cancer ❑ Cause of Death										
Other Cancer not mentioned:										
Other:										

GYNECOLOGICAL HISTORY: (*Fill in blanks or check boxes where appropriate*)

1. Age at first menstrual period: ____ years **2.** Days between the first day of each period: ____ days
3. Length of each period: _____ days **4.** Flow: ❑ Light ❑ Medium ❑ Heavy
5. Number of Tampons used per day _____ **6.** Number of Pads used per day _____
7. LMP -Last normal menstrual period: ____/____/_____ ***(First day of last menstrual period)***
8. Breakthrough bleeding: ❑ Yes ❑ No **9.** Clots: ❑Yes ❑ No Size of clots: ❑ "Nickel" ❑ "Quarter" ❑"Half-Dollar"
10. Menopausal Status: ❑ Premenopausal ❑ Perimenopausal ❑ Postmenopausal **11.** Age at Menopause _____
12. Do you use contraception? ❑ Yes ❑ No *(If yes, please check type)*

❑ Birth Control Pills ❑ Depo Provera ❑ Condoms ❑ Tubal ligation/Essure®
❑ NuvaRing ❑ IUD ❑ Foam ❑ Vasectomy
❑ Ortho Evra ❑ Diaphragm ❑ Natural Family Planning ❑ Other _____

OBSTETRICAL HISTORY:

Pregnancies ____ Full-Term ____ Pre-term ____ Abortions ____ Miscarriages ____ Tubal Pregnancies ____ Multiple ____ Living ____

Date	Weeks	Labor Hrs	Weight	Sex	Delivery Type	Anesthesia	Early Labor?	Complications	Location/Physician

SOCIAL HISTORY:

Marital Status: ❑ Dating ❑ Divorced ❑ Engaged ❑ Married ❑ Not Dating ❑ Separated ❑ Single ❑ Widowed
Are you sexually active? ❑ Yes ❑ No
Education: Grade completed _____ ❑ Graduated High School ❑ GED ❑ Some College
❑ Graduated College – 2 YR ❑ Graduated College – 4 YR ❑ Postgraduate
Tobacco Use ❑ Never ❑ Current ❑ Former Amount_____ Started_____ Stopped _____
Alcohol Use ❑ Never ❑ Current ❑ Former Amount_____ Started_____ Stopped _____
Recreation Drug Use ❑ Never ❑ Current ❑ Former Type _____ Started_____ Stopped _____
Occupation _____
Hazard Exposure ❑ Yes ❑ No If Yes Describe Exposure _____
Do you exercise regularly ❑ None ❑ Minimal ❑ Moderate ❑ Heavy ❑ Active but no formal exercise
Domestic Violence ❑ Yes ❑ No If Yes Describe Violence_____
Travel History: Do you use your seat belt? ❑ Yes ❑ No Any Travel Related Illnesses? _____
Military History ❑ Yes ❑ No If Yes Which Branch?_____
Current Problem or Chief Complaint:_____