Women's Medical Care of Hudson Valley, P.C.

PATIENT NAME: ______________________________DATE: ________________________

PHYSICAL HISTORY +/-	PERSONAL HISTORY	FAMILY HISTORY
Rhuematic Fever		
Heart Disease		
Kidney Disease		
Tuberculosis		
High Blood Pressure		
Thyroid Disease		
Hepatitis		
Mono		
Gastro-intest		
Seizures		
Diabetes		
Urinary Tract Infection		
Gonorrhea		
Syphilis		
Chlamydia		
Herpes		
Condyloma (warts)		
HIV (AIDS)		
Breast Cancer		
Colon Cancer		
Ovarian Cancer		
Blood Transfusion		
Osteoporosis		

GYN HISTORY:

Age Period Started_________________

# of Days Cycle Lasts _____________

# of Days Between Cycles___________

Contraceptive History _____________________

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PREGNANCY HISTORY:

# of Pregnancies____________________

# of Deliveries Vaginal_____________

C-Section___________

# of Terminations___________________

# of Miscarriages___________________

SOCIAL HISTORY:

Cigarettes_________________________

Alcohol___________________________

Drugs____________________________

MEDICATIONS: _________________

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SURGICAL HISTORY:

Year________________Doctor___________________Type of Surgery___________________

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ALLERGIES to MEDICATION or FOOD:____

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MEDICATIONS:____

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