Dr Summers W Taylor III
OBGYN

Patient Medical History

Name: _____ DOB: _____

Health Maintenance Screening Test:

Colonoscopy	☐ Yes ☐ No	If yes, date: / /	Results:	☐ Normal	☐ Abnormal
Dexa Scan	☐ Yes ☐ No	If yes, date: / /	Results:	☐ Normal	☐ Abnormal
Mammogram	☐ Yes ☐ No	If yes, date: / /	Results:	☐ Normal	☐ Abnormal

Pap Smear History:

Pap Smear	☐ Yes ☐ No	If yes, date: / /	Results:	☐ Normal	☐ Abnormal
Colposcopy	☐ Yes ☐ No	If yes, date: / /	Results:	☐ Normal	☐ Abnormal
History of HPV	☐ Yes ☐ No	If yes, date: / /	Results:	☐ Normal	☐ Abnormal

Personal Medical History: Check if you had any of these medical problems in the past.

Major illness	Yes	Major illness	Yes
Anemia		Hepatitis ___A ___B ___C	
Anxiety		High Blood Pressure	
Asthma		High Cholesterol	
Depression		Hypothyroid	
Diabetes Type 1		Hyperthyroid	
Diabetes Type 2		Kidney / Bladder	
Uterine Fibroids		Migraines	
Fracture		Osteopenia	
GERD		Osteoporosis	
Heart Disease		Ovarian Cancer	
Cancer:		Seizures	
1. Breast Cancer		Sexually Transmitted Disease	
2. Uterine Cancer		Stroke	
3. Ovarian Cancer		HIV	
4. Other			

Gynecology:

Age of first period:	1st Day of last period: _____/_____/_____
Frequency of Period:	Is your Period: Light Normal Heavy
Length of Period:	Current Birth Control:
Are you in Menopause?	Are you on Hormone Replacement Therapy?

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Obstetrics:

Total # Pregnancies		Abortions Induced	
Full Term Births		Miscarriages	
Pre-Term Births		Living Children	

No.	Birth Date	#Weeks at Delivery	Sex	Birth Weight	Delivery Type	Complications	Location of Delivery
1.							
2.							
3.							
4.							
5.							
6.							
7.							

Social History:

Do you drink? ☐ Yes ☐ No ☐ Social Drinker ☐ Daily

Do you use tobacco? ☐ Yes ☐ No Current every day_____ or Some Days_____

Former Smoker _____ Never _____ If current how many a day? _____

Do you use recreational drugs? ☐ Yes ☐ No What kind? _____

Past Surgical History: ☐ **No past surgical history**

Year	Surgery / Surgeon

Current Medications: ☐ None (If there is not efficient space please attach a copy of meds list)

Medication	Dosage (mg)	Frequency	Prescribing Physician

Allergies: (Food, Drugs, Environmental) ☐ **None** ☐ **Latex** **Iodine** ☐

Allergy	Interaction	Allergy	Interaction

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Family Medical History: Please indicate below the significant medical problems of family members. Indicate which family member by checking the appropriate column and the AGE OF ONSET:

☐ No Family History ☐ Adopted

Family Member	Age of onset	None	Breast Cancer	Cervical Cancer	Colon Cancer	Diabetes	Ovarian Cancer	Uterine Cancer	
Father									
Mother									
Brother									
Sister									
Maternal Grandmother									
Paternal Grandmother									
Maternal Grandfather									
Paternal Grandfather									

Any other diseases not mentioned

_____

_____

_____

PATIENT SIGNATURE: _____