NATHAN FUJITA MD. | **OBSTETRICS & GYNECOLOGY**
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MEDICAL HISTORY - PAGE 1

Name _____ Date _____ /_____ /_____
Month Day Year

What was the first day of your last menstrual period? _____

Was the period normal? ☐ **NORMAL** or ☐ **ABNORMAL**

Are you certain of this date? ☐ **CERTAIN** or ☐ **UNCERTAIN**

How old were you when you had your first period? _____

Are your periods normally: ☐ **REGULAR** or ☐ **IRREGULAR**

How often do you usually get your period? Every _____ days.

For how long do you usually flow? . . . . . For _____ days.

Pain/cramps with your period? ☐ **YES** ☐ **NO** ☐ **SOMETIMES**

Heavy bleeding and/or blood clots with your periods?
☐ **YES** ☐ **NO** ☐ **SOMETIMES**

How many times have you been pregnant? . . . . . _____

How many live births? . . . . . _____

How many miscarriages? . . . . . _____

How many abortions? . . . . . _____

What are you using for birth control? _____

Date of Last Pap Smear _____ Normal?_____

Date of Last Mammogram _____ Normal?_____

Date of Last Bone Density _____

Date of Last Colonoscopy? _____

PLEASE LIST ALL PAST PREGNANCIES

PREGNANCY NUMBER	DATE	WEEKS PREGNANT	VAGINAL OR C-SECTION	LENGTH OF LABOR	ANESTHESIA	HOSPITAL	SEX OF BABY	COMPLICATIONS
1								
2								
3								
4								
5								

HAVE YOU HAD ANY OF THE FOLLOWING SURGICAL PROCEDURES?

YES	NO	CONDITION	MONTH / YEAR	PLEASE EXPLAIN ANY IMPORTANT DETAILS
☐	☐	GALLBLADDER REMOVAL		
☐	☐	APPENDIX REMOVAL		
☐	☐	BREAST BIOPSY		
☐	☐	BREAST ENLARGEMENT OR REDUCTION SURGERY		
☐	☐	ORAL SURGERY		
☐	☐	PLASTIC SURGERY		
☐	☐	TUBAL SURGERY		
☐	☐	LAPAROSCOPY		
☐	☐	D & C (DILATATION AND CURETTAGE)		
☐	☐	ANY OTHER SURGERY?		
☐	☐	ANY OTHER SURGERY?		

SOCIAL HISTORY

Did you consume any alcohol recently?
☐ **YES** ☐ **NO**

Do you smoke tobacco?
☐ **CURRENT SMOKER** ☐ **FORMER SMOKER** ☐ **NEVER SMOKER**

Within the past 2 weeks have you been feeling:
down, depressed, or hopeless?
☐ **YES** ☐ **NO**

Within the past 2 weeks have you had:
little interest or pleasure in doing things?
☐ **YES** ☐ **NO**

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MEDICAL HISTORY – PAGE 2

Current Illnesses:	Primary Care Physician _____ Primary Language _____ Primary Ethnicity _____ ☐ Hispanic ☐ Non-Hispanic

Current Medications:	Allergies:

HAS ANYONE IN YOUR FAMILY SUFFERED FROM THE FOLLOWING?

	DISORDER / ILLNESS	RELATIONSHIP (MOTHER/FATHER/ MATERNAL OR PATERNAL GRANDPARENT)		DISORDER / ILLNESS	RELATIONSHIP (MOTHER/FATHER/ MATERNAL OR PATERNAL GRANDPARENT)
☐	DIABETES		☐	THYROID DISEASE	
☐	STROKE		☐	BREAST CANCER	
☐	BLOOD DISORDER		☐	MENTAL DISORDER	
☐	HEART DISEASE		☐	OVARIAN CANCER	
☐	HIGH BLOOD PRESSURE		☐	COLON CANCER	
☐	BIRTH DEFECTS		☐	OTHER (IF CANCER, TYPE:) _____	

HAVE YOU HAD PROBLEMS WITH ANY OF THE FOLLOWING WITHIN THE PAST YEAR?

GENERAL
- ☐ Weight Loss or Gain
- ☐ Fevers
- ☐ Trouble Sleeping
- ☐ Chronic Fatigue
- ☐ Excessive Bleeding
- ☐ Easy Bruising
- ☐ Abnormal Thirst

EYES
- ☐ Itchy, Red Eyes
- ☐ Vision Problems

EARS
- ☐ Ear Pain
- ☐ Ringing in Ears
- ☐ Hearing Loss

NOSE
- ☐ Sinus Problems
- ☐ Nose Bleeds

MOUTH
- ☐ Sore Throat
- ☐ Mouth Sores
- ☐ Dental Problems

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Ankle/Hand Swelling

LUNGS
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Blood Clot in the Lungs
- ☐ Painful Breathing
- ☐ Wheezing

GASTROINTESTINAL
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Bloody Stools
- ☐ Nausea/Vomiting
- ☐ Hemorrhoids

URINARY
- ☐ Incomplete Urination
- ☐ Loss of Urine
- ☐ Painful Urination
- ☐ Bloody Urine

MUSCULOSKELETAL
- ☐ Muscle Weakness
- ☐ Joint Pains
- ☐ Joint Swelling
- ☐ Clot in Leg Vein

NEUROLOGIC
- ☐ Frequent/Severe Headaches
- ☐ Dizziness
- ☐ Seizures
- ☐ Numbness
- ☐ Trouble Walking
- ☐ Fainting Spells

SKIN
- ☐ Acne
- ☐ Unwanted Hair Growth
- ☐ Unusual Lump or Growth
- ☐ Dry Skin

EMOTIONAL
- ☐ Excessive Worry
- ☐ Depression
- ☐ Frequent Crying
- ☐ Serious thoughts of harming yourself or others

DEPRESSION SCREENING

Within the past 2 weeks have you been/had:

Feeling down, depressed or hopeless? ☐ YES ☐ NO

Little interest or pleasure in doing things? ☐ YES ☐ NO

MENSTRUAL PROBLEMS
- ☐ Cramps/Pain
- ☐ Heavy Bleeding
- ☐ Too Frequent Periods
- ☐ Bleeding Between Periods
- ☐ Missed a Period
- ☐ Other Period Issue

PRE MENSTRUAL PROBLEMS
- ☐ Bloating/Swelling
- ☐ Mood Changes
- ☐ Breast Changes
- ☐ Headaches
- ☐ Acne
- ☐ Other PMS Issue

MENOPAUSE ISSUES
- ☐ Hot Flashes
- ☐ Night Sweats

BREAST PROBLEMS
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Nipple Discharge
- ☐ Other Breast Issue

OTHER GYNECOLOGIC ISSUES
- ☐ Vaginal Discharge
- ☐ Itching/Irritation
- ☐ Vulvar Pain
- ☐ Vulvar lump/growth
- ☐ Vulvar Sores

SEXUAL PROBLEMS
- ☐ Painful Intercourse
- ☐ Bleeding after Intercourse
- ☐ Decreased Desire
- ☐ Orgasm Problems
- ☐ Dryness
- ☐ Possible Exposure to STD
- ☐ Other Sexual Issue

WOULD YOU LIKE TO DISCUSS ANY OF THE FOLLOWING?
- ☐ Contraception
- ☐ Menopause Issues
- ☐ Pregnancy Issues
- ☐ Self Breast Exam
- ☐ Sexuality Issues
- ☐ STD's
- ☐ Other

Signature _____ Date _____ /_____ /_____