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PAST MEDICAL HISTORY

Name: ___________________________________

1) Date of last pelvic exam/PAP: _____ Results: ______ Any Past Positive PAP: ________

2) Reproductive History: # of preg: _______ Relevant History of Births (date, type, etc):

____

____

3) Please list any pelvic or abdominal surgeries:

____

____

4) If applicable, please list types of birth control/length of time utilized:

____

____

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5) If you have now, or had in the past, any of the following, please check and explain with dates:

____ low back pain ___________________

____ menstrual pain/PMS ______________

____ pain during sex __________________

____ fibroids/cysts ____________________

____ hemorrhoids ____________________

____ tearing with birth ________________

____ sexual abuse ____________________

____ depression ______________________

____ drug abuse ______________________

____ eating disorder __________________

____ pelvic/abdominal pain ____________

____ prolonged bleeding ______________

____ altered cycles ___________________

____ sexually transmitted infection _____

____ herpes _________________________

____ UTI/bladder infections ____________

____ constipation/irritable bowel _______

____ childbirth complications __________

____ abortion/miscarriage _____________

____ physical/other abuse _____________

____ cancer __________________________

____ smoking habit ___________________

____ autoimmune ____________________

____ lyme ___________________________