



**MEDICATIONS:**

Are you presently taking any of the following medications? (Circle)

- |     |    |                                |     |    |   |
|-----|----|--------------------------------|-----|----|---|
| Yes | No | Aspirin, Bufferin, Anacin      | Yes | No | Tranquilizer                                |
| Yes | No | Blood pressure pills           | Yes | No | Weight reducing pills                       |
| Yes | No | Cortisone                      | Yes | No | Blood thinning pills                        |
| Yes | No | Cough medicine                 | Yes | No | Dilantin                                    |
| Yes | No | Digitalis (Heart pills)        | Yes | No | Shots                                       |
| Yes | No | Hormones                       | Yes | No | Water Pills                                 |
| Yes | No | Insulin or diabetic pills      | Yes | No | Antibiotics                                 |
| Yes | No | Iron or poor blood medications | Yes | No | Barbiturates                                |
| Yes | No | Laxatives                      | Yes | No | Birth control pills, brand name: _____      |
| Yes | No | Sleeping pills                 | Yes | No | Phenobarbital                               |
| Yes | No | Thyroid medicine               | Yes | No | Other drugs not listed. If so, please list. |

\_\_\_\_\_  
\_\_\_\_\_

List the operations (major or minor) you have had as well as the hospital location and date: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Name any drugs to which you are allergic, and state the reaction you have had: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Write in the names of any diseases or illnesses you have now or had in the past: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Serious injuries or accidents: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**MENSTRUAL HISTORY:**

Age at onset of Menses \_\_\_\_\_ Duration of Menses \_\_\_\_\_ Interval between Menses \_\_\_\_\_

First day of last menstrual period: \_\_\_\_\_

(CIRCLE)

- Yes No Have you ever missed a period except when pregnant?
- Yes No Has your period ever lasted more than eight days or less than two days?
- Yes No Did you ever pass large clots during your period?

**CONTRACEPTIVE HISTORY:**

- Yes No Have you ever taken birth control pills?
- Yes No Are you presently taking birth control pills? Which one? \_\_\_\_\_
- Yes No If no, what form of contraception do you use? \_\_\_\_\_



DO NOT WRITE **IN SHADED AREA**

**Office Tests**

**Height:** \_\_\_\_\_ **Feet** \_\_\_\_\_ **Inches**

**Weight (lbs.):** \_\_\_\_\_

**Blood Pressure:** \_\_\_\_\_

**Pulse:** \_\_\_\_\_

**Urinalysis: Blood** \_\_\_\_\_ **Keotone** \_\_\_\_\_

**Protein** \_\_\_\_\_ **pH** \_\_\_\_\_

**Leukocytes:** \_\_\_\_\_

**Micro (if done)** \_\_\_\_\_

**Hematocrit:** \_\_\_\_\_

**Wet Smear:** \_\_\_\_\_

**Urine Pregnancy Test:** \_\_\_\_\_



**Notes:**

Multiple horizontal lines for writing notes.