BAYSIDE WOMEN'S HEALTH
NEW PATIENT MEDICAL HISTORY

Name:	**Date:**	**Chart #:**

MENSTRUAL HISTORY: **Age Started:_____**

Regular ___ Irregular___ | Length of Flow: _____(Days) | Cramps____ Clots____ Headaches____

Date of last Pap Smear: _____ **Normal _____ Abnormal_____**	**History of Abnormal Pap Smears?** _____

PERSONAL MEDICAL HISTORY/MAJOR ILLNESSES:

NONE		Hepatitis		Crohn's		BL Transfusion		Sickle Cell	
Heart		Asthma		Ulcers		Epilepsy		Phlebitis	
Arthritis		Cancer		STD		High BP		Varicose Veins	
Migraines		Diabetes		Thyroid		Anemia		Other	

SURGICAL HISTORY: **Date:**	**Type of Operation:**

PREGNANCY HISTORY: (List the # of times you have had the following. *including currently*)

Pregnant		Full-term Delivery		Stillborn		Premature Delivery		Miscarriage	
Abortion		Living Children		Infant Death		C-Section		Other	

List <u>ALL</u> Pregnancies IN ORDER: (Include abortions, miscarriages, etc.)

Sex:	**Birth Weight:**	**Date of Birth:**	**RhoGAM:**	**Complications Before or After Delivery:**