Kathy E Wolf MD PC
Bringing hope through compassionate healthcare

Name:_____ **DOB**_____ **Date** _____

Personal Medical History

Please list allergies:_____

List all medications including over the counter medicines:_____
_____
_____

Past Medical History
(Please circle and use the line follow for description)

Migraine Headaches Yes No Date of onset:_____
Have you had a workup by an internist or neurologist? Yes No
Thyroid disease Yes No _____
Breast disease such as tumors, lumps, cysts, or discharge Yes No
Diabetes Yes No If yes, Type 1 or Type 2 Date/Age of Onset_____
High Blood Pressure Yes No
Heart disease such as:
heart attack Yes No If yes, date of occurrence _____
heart murmur Yes No
If yes, do you take antibiotics at the dentist office or before surgery? _____
rheumatic fever Yes No
stroke Yes No
high cholesterol Yes No
blood clot in extremities or lungs Yes No
Lung disease Yes No _____
Kidney disease or stones Yes No _____
Urinary tract infections Yes No
Liver disease Yes No _____
Gall bladder disease Yes No
Blood disease
sickle cell anemia Yes No
clotting problems Yes No
Bleeding disorders Yes No
Cancer Yes No
If Yes, what type _____Diagnosed when_____

Depression: Yes No Anxiety: Yes No Other mental health disorders _____ _____
Other Medical History _____

Gynecological History

Age at first menstrual period_____Periods occur every _____days and last for _____days.
Date of the first day of your last menstrual period _____ Any bleeding in between? _____
If you are in menopause, date/age at which your periods stopped _____
Are you sexually active? Yes No If No, have you ever been sexually active?_____
How many sexual partners have you had within the last 5 years? _____
Do you have a female partner?_____
What method do you use to keep from getting pregnant? None Natural Family Planning
Condoms Diaphragm Birth control pills IUD Tubal ligation/Essure Vasectomy

Date of last pap smear _____
Have you ever had an abnormal pap smear? Yes No
Have you ever had a colposcopy for an abnormal pap? Yes No If yes, date_____
Have you ever had cryosurgery, a cone biopsy, or a LEEP procedure? Yes No
If yes, date of procedure_____

Have you ever had a sexually transmitted disease? Yes No Gonorrhea Syphilis
Herpes Chlamydia Warts Human Papilloma Virus(HPV) HIV Trichomonas Other

Have you had the HPV vaccine? _____ If yes, did you receive all three doses? _____

Do you have: endometriosis uterine fibroids PCOS PMS Ovarian cysts

Pregnancy History

Number of pregnancies _____ Number of living children_____ Age of Children _____

Have you ever had:
miscarriage Yes No abortion Yes No
ectopic pregnancy Yes No cesarean section Yes No
Did you have problems during pregnancy?_____
Do you plan more children in the future? Yes No

Surgical/Hospital History

Please list any hospitalizations or surgeries and dates:_____
_____
_____
_____
_____
_____

Family History

Has anyone in your family had: (Please name who and age at diagnosis, if you know.)

High blood pressure Yes No _____
High cholesterol Yes No _____
Heart Attack Yes No _____
Stroke Yes No _____
Breast cancer Yes No _____
Ovarian cancer Yes No _____
Colon cancer Yes No _____
Uterine cancer Yes No _____
Osteoporosis Yes No _____
Diabetes Yes No _____ ____
Blood clot in lungs or extremities Yes No _____

Tested positive for the breast cancer gene Yes No _____

Did your mother take DES while pregnant with you? Yes No

Father Living Deceased If deceased, cause of death _____age_____

Mother Living Deceased If deceased, cause of death_____age_____

Siblings Living Deceased If deceased, cause of death_____age_____

Social History

Are you: Single Married Occupation:_____

Do you smoke? Yes No If yes, how many cigarettes/day_____

Do you use alcohol? Yes No If yes, how many drinks/week _____

Do you use street drugs? Yes No If yes, which ones_____ _____