

# Stephen R. Stanley, D.O., Inc.

Marietta Health Care Physicians, Inc.

## MEDICAL HISTORY

Reason you are being seen today

Past Surgeries	
Date	Procedure

Please describe your medical condition

Past Hospitalizations	
Date	Reason

Current Medication	
<i>Medication</i>	<i>Dose</i>

Family History	
<i>Relative</i>	<i>Medical Problem</i>
Mother	
Father	
Sister	
Brother	
Daughter	
Son	
Maternal Grandmother	
Paternal Grandmother	
Maternal Aunt	
Cousins	
Other	

Known Allergies	
<i>Medication</i>	<i>Reaction</i>

Social History	
Occupation	
Alcohol	
Tobacco	
Illicit drugs	
Physical abuse	
Sexual abuse	

Medical History	
<i>Medical Problem</i>	<i>Status</i>

Print Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Today's Date \_\_\_\_\_

Signature \_\_\_\_\_

**Stephen R. Stanley, D.O., Inc.**

Marietta Health Care Physicians, Inc.

**GYN REVIEW OF SYSTEMS**

Please indicate and provide details of any condition in your current history

Yes	No	Condition	Details
		Anorexia/Bulimia	
		Headache	
		Dizziness	
		High blood pressure	
		Chest pain	
		Heart problems	
		Shortness of Breath	
		Rash	
		Abdominal pain	
		Constipation	
		Diarrhea	
		IBS – Irritable Bowel Syndrome	
		Endometriosis	
		Infertility	
		Frequent urination	
		Urinary Incontinence	
		Recurrent bladder/Urinary infections	
		Bleeding tendencies	
		Blood transfusions	
		Anemia	
		Hepatitis	
		Lack of sex drive	
		Leaking milk from breasts	
		Thyroid problems	
		Depression	
		Difficulty sleeping	
		Seizures	
		Alzheimer’s disease	
		Multiple sclerosis	
		Bipolar disorder	
		Stroke	
		Mental or physical abuse	
		Sexual abuse	

Print Name \_\_\_\_\_

Date Of Birth \_\_\_\_\_

Signature \_\_\_\_\_

Today’s Date \_\_\_\_\_

