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

MEDICAL HISTORY

Reason you are being seen today

Please describe your medical condition

Current Medication	
Medication	*Dose*

Known Allergies	
Medication	*Reaction*

Medical History	
Medical Problem	*Status*

Past Surgeries	
Date	Procedure

Past Hospitalizations	
Date	Reason

Family History	
Relative	*Medical Problem*
Mother	
Father	
Sister	
Brother	
Daughter	
Son	
Maternal Grandmother	
Paternal Grandmother	
Maternal Aunt	
Cousins	
Other	

Social History	
Occupation	
Alcohol	
Tobacco	
Illicit drugs	
Physical abuse	
Sexual abuse	

Print Name _____

Date of Birth _____

Today's Date _____

Signature _____

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

GYN REVIEW OF SYSTEMS

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

Yes	No	Condition	Details
		heavy periods	
		dyspareunia – pain during sex	
		sexually active	
		premenstrual syndrome	
		dysmenorrhea – pain during period	
		iInfertility	
		inter-menstrual bleeding	
		post coital bleeding – bleeding after sex	
		pelvic pain	
		irregular periods	
		abnormal vaginal discharge	
		weight gain	
		weight loss	
		rash	
		lumps	
		breast changes	
		chest pain	
		palpitations	
		dizziness	
		shortness of breath	
		nausea	
		vomiting	
		diarrhea	
		abdominal pain	
		constipation	
		rinary urgency	
		frequent urination	
		urinary incontinence	
		fatigue	
		excessive thirst	
		excessive urination	
		cold tolerance	
		heat tolerance	
		headache	
		high stress level	
		depression	
		sleep disturbances	
		mental or physical abuse	
		sexual abuse	

Print Name _____

Date Of Birth _____ Signature _____

Today's Date _____

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

OB/GYN HISTORY

Gynecologic History	
Last Menstrual Period	
Menarche (age of first menses)	
Menstrual regularity	
Menopause (age of last menses)	
Contraception	
Abnormal PAP	
Abnormal Mammogram	
Last PAP	
Last Mammogram	
Sexually Transmitted Disease	
Pelvic Inflammatory Disease	
Urinary Incontinence	

Obstetrical History	
Total Pregnancy's	
Living Children	
Miscarriage	
Abortion	
Ectopic Pregnancy	
Vaginal Delivery	
Cesarean Section	

Print Partners Name

_____

Last First Middle

Pregnancy History	1st Pregnancy	2nd Pregnancy	3rd Pregnancy	4th Pregnancy	5th Pregnancy
Date					
Weeks Pregnant					
Labor Length					
Weight at Delivery					
Gender					
Mode of Delivery					
Anesthesia					
Place of Birth					
Baby's Name					
Complications					

Name _____

Date of Birth _____

Today's Date _____ Signature _____