Rex OBGYN
Medical History Form

Name: _____ Date: _____

Occupation: _____

Marital Status: _____

Major Medical Diagnosis and Year Diagnosed:

_____

_____

Allergies to any Medication or Latex and the reaction they cause:

_____

_____

Major Operations and the year they were performed:

_____

_____

Number of Pregnancies: _____

Number of miscarriages: _____

Number of live Births: _____

Number of Abortions: _____

Age when you had your first Period: _____

Last Menstrual Period: _____

How long does period last: _____

How many days between cycles: _____

Date of last Pap smear and the results: _____

If abnormal Pap, what was your treatment:

_____

Do you drink alcohol and if so, how often: _____

Do you smoke and if so, how much: _____

Any family history of GYN cancers:

_____

_____

List all current medications:

_____

_____

_____

What Pharmacy do you use? _____

Any other concerns you have related to your past health history:

_____

_____

_____