Date of Birth_________________

CHOICES Medical History (all information is confidential)

Legal Name______________________________ Preferred Name_______________________ Preferred Pronoun He/She/They

Primary Reason for visit____

General Medical History (have you ever had)

- ☐ Diabetes
- ☐ Cancer
- ☐ Hypertension
- ☐ Lung/respiratory problems
- ☐ Heart problems
- ☐ Blood clots in arms/legs/lungs
- ☐ Anxiety or Depression
- ☐ Seizures/Epilepsy
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Other___________________________________
- ☐ None of the Above

OB/Gyn History

Number of pregnancies_____________________________

- ☐ Full term____________
- ☐ Preterm_____________
- ☐ Abortion_____________
- ☐ Miscarriage___________
- ☐ Vaginal Delivery________
- ☐ C-Section______________
- ☐ Complications in pregnancy_________________________

Last Menstrual period__________________

- ☐ Regular
- ☐ Irregular

Previous Contraception used

- ☐ Birth control pills___________________________________
- ☐ Patches____
- ☐ Condoms____
- ☐ DepoProvera injection______________________________
- ☐ Mirena/Liletta_____________________________________
- ☐ Paragard____
- ☐ Nexplanon____
- ☐ Withdrawl____
- ☐ Rhythm ____
- ☐ Tubal ligation______________________________________
- ☐ Vasectomy____
- ☐ Other____

Other OB/GYN History

- ☐ Fibroids ____
- ☐ Ovarian Cysts______________________________________
- ☐ Hormone replacement therapy_______________________
- ☐ Breast problems____________________________________
- ☐ Abnormal pap smear_________________________________
- ☐ Chlamydia____
- ☐ Gonorrhea____
- ☐ Herpes____
- ☐ Syphilis____
- ☐ HIV____
- ☐ Other ____

Previous Hospitalizations/Surgeries

____
____
____

Allergies

- ☐ No known allergies
- ☐ Latex
- ☐ Novocaine/Lidocaine
- ☐ Iodine
- ☐ Any medications (please list medication allergy and type of reaction below)

____
____
____

Medications (use extra form if you need more room)

- ☐ Not taking any medication

Prescription Medications (please list name and dosage below)

- ☐ Name________________________Dose_______________
- ☐ Name________________________Dose_______________
- ☐ Name________________________Dose_______________

Over the counter Medications

- ☐ Name________________________Dose_______________
- ☐ Name________________________Dose_______________
- ☐ Name________________________Dose_______________

Social History

- ☐ Smoke cigarettes, how many per day?_________________
- ☐ Marijuana use, how frequently?______________________
- ☐ Drug use, type and frequency?______________________
- ☐ Alcohol use, how frequently?________________________
- ☐ I am experiencing neglect, violence or abuse

Family History (parents, brothers or sisters)

- ☐ Hypertension____________________________________
- ☐ Diabetes____
- ☐ Cancer____
- ☐ Genetic illness____________________________________
- ☐ Other____

____

Please describe any other issues or concerns that you need to discuss with your health care provider today

____
____
____
____

Patient Signature: ____Date:_________________________

Provider Signature:____Date:_________________________