Tufts Medical Center

Women's Care South at Tufts Medical Center
15 Braintree Hill Office Park, Suite 201, Braintree, MA 02184
Telephone: 781-843-2229 Fax: 781-848-2227

INITIAL MEDICAL HISTORY

Name: _____ Date: _____

What do you prefer to be called? _____ Age: _____ Birthdate: _____

What is the reason for your visit today? _____

_____

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS

Please check any items you have had problems with:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ Chest Pain or Tightness
- ☐ Swollen Ankles
- ☐ Palpitations
- ☐ Light-headedness
- ☐ Frequent Urination
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Cough
- ☐ TB
- ☐ Hay Fever
- ☐ Abdominal Pain
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Change in Bowels
- ☐ Ulcers
- ☐ Weight Loss/Gain
- ☐ Hemorrhoids
- ☐ Gallbladder
- ☐ Colitis
- ☐ Hepatitis/Jaundice
- ☐ Thyroid Disease
- ☐ Head or Neck Radiation
- ☐ Headaches
- ☐ Kidney or Bladder Infection
- ☐ Kidney Stones
- ☐ Problem with Urinating
- ☐ Low Back Problems
- ☐ Arthritis
- ☐ Skin Diseases
- ☐ Blood Disorders
- ☐ Sexually Transmitted Infections
- ☐ Anxiety/Panic Attacks
- ☐ Depression
- ☐ Problem Drinking
- ☐ Street Drug Use
- ☐ Gout
- ☐ _____

GYNECOLOGIC HISTORY

Date of last menstrual period? _____ Number of pregnancies? _____

How many days to your periods last? _____ Number of miscarriages? _____

How often do you get your period? _____ Number of terminations? _____

Age at first intercourse? _____ Age at first period? _____

Are you sexually active now? ☐ Yes ☐ No
Have you recently had sex with a new partner? ☐ Yes ☐ No
If yes, was your last partner a male or female? ☐ Male ☐ Female
Have you ever had intercourse against your will? ☐ Yes ☐ No
Do you experience pain with intercourse? ☐ Yes ☐ No
Prolonged/abnormal bleeding? ☐ Yes ☐ No
Leakage of urine? ☐ Yes ☐ No
Pelvic pain? ☐ Yes ☐ No
Abnormal discharge? ☐ Yes ☐ No
Prior abnormal Pap Smear? ☐ Yes ☐ No
Hot flashes? ☐ Yes ☐ No
Vaginal dryness? ☐ Yes ☐ No
Problems with sexuality? ☐ Yes ☐ No
Do you desire STD/HIV testing? ☐ Yes ☐ No

(please turn over and complete opposite side)

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CURRENT MEDICATION

Please list all prescription drugs, over the counter medicines, vitamins and herbs

Medication	Dose	Doctor

BIRTH CONTROL HISTORY

Please complete the following, listing the most recently used method first

Method Used	Date Started	Date Stopped	Reason for Stopping

PREGNANCY HISTORY

Please list all pregnancies and their outcome

Month & Year	Type of delivery, miscarriage or abortion	Infant Sex	Infant Weight	Complications	Hospital

SURGICAL HISTORY

Please list all operations you have had in your lifetime

Operation	Date	Anesthesia	Doctor	Hospital

OTHER HOSPITALIZATIONS

Please list all other OVERNIGHT hospital stays in your lifetime

Reason for Admission	Date	Hospital	Doctor	Length of Stay