

Insignia Clinical Research

MEDICAL HISTORY FORM

Please print clearly

Date _____

Name _____ Age _____ S M W D Sep _____ Occupation _____
Husband _____ Age _____ Health _____ Occupation _____
Contact phone # for lab results _____ Family Doctor _____
Email Address _____

Obstetrical History:

Indicate # of:

Full Term Babies _____ Premature _____ Stillborn _____ Miscarriages _____
Abortions _____ Number of Living Children _____

Please list your pregnancies in chronological order below

Year Sex WT Vaginal or Cesarean Hospital Name of Child Any Complications

Year	Sex	WT	Vaginal or Cesarean	Hospital	Name of Child	Any Complications

Gynecological History: Age of initial menstrual period _____ Onset of last period _____
Period every _____ days Lasting _____ days Menses reg. or irreg. _____
Any problems with periods _____

Current contraceptive method: Birth control pills (Brand) _____
Diaphragm _____ Condoms _____ Depo Provera _____
Norplant _____ IUD _____ Tubal _____
Sponge _____ Vasectomy _____ Foam, Spermicides _____
Other _____

Date of last mammogram _____ Normal or Abnormal _____

Date of last pap smear _____ Normal or Abnormal _____

Any Treatment in the Past for Abnormal Pap Smear _____

Family History: Has any blood relative ever had (please circle and indicate whom)

Birth Defects _____ Heart Disease or Attacks _____ Stroke _____
Thyroid _____ High Blood Pressure _____ Diabetes _____
Epilepsy _____ Mental Disorder _____ Kidney Disease _____
Tuberculosis _____ Blood Clotting Problems _____

Relative	Age	Status of Health	Cause of Death
Mother			
Father			
Brothers			
Sisters			

PLEASE FILL OUT OTHER SIDE

Female Cancer History: (Please circle and indicate if it is your sister, mother, maternal aunt, or maternal grandmother; also the age of diagnosis)

Breast _____ Ovarian _____ Uterine _____ Cervical _____

Social History:

Smoking: Do you smoke? _____ How many packs a day? _____ How many years? _____

Alcohol: Do you drink? _____ Rare Social Moderate History of Alcoholism _____

History of drug abuse or addiction? _____

Personal Medical History: (Please circle)

AIDS	Headaches	Anemia	Hepatitis
Arthritis	Herpes	Birth Defects	High Blood Pressure
Bladder Infections	Infection of Tubes/Ovaries	Bleeding Problems	Kidney Problems
Blood Transfusion	Liver Problems	Bowel Problems	Phlebitis
Brain or Spinal Problems	Seizures	Breast Problems	Syphilis
Cancer	Thyroid Problems	Chlamydia	Tuberculosis
Condyloma/HPV	Ulcers	Diabetes	Varicose Veins
Gallbladder Problems	Visual/Hearing Problems	Gonorrhea	
Other _____			

Please list any Operations or Hospitalizations you have had (excluding pregnancy):

Year	Reason

Are you allergic to any medications? _____

Name	Reaction

Please list all medications you are currently taking: (This includes prescription and non-prescription medication)

Medication	Reason	Dosage

Major Health Concern at present time: _____

Patient Signature _____ Date _____

Date Reviewed _____ Physician Signature _____