Patient Medical Information

1. List any medical problems you or your partner may have:

You	Your Partner
_____	_____
_____	_____

2. List any surgeries you or your partner have had:

You	Your Partner
_____	_____
_____	_____

3. List all medications you or your partner are currently taking:

You	Your Partner
_____	_____
_____	_____

4. Have you or your partner had any sexually transmitted diseases?

You	Your Partner
_____	_____

5. Do you or your partner drink, smoke or use illicit drugs? If yes, please list

You	Your Partner
_____	_____

6. List all your previous pregnancies and their outcomes by year:

Month/Year	Pregnancy Outcome	Month/Year	Pregnancy Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. List all your previous treatments and their outcomes by year:

Month/Year	Treatment/Outcome	Month/Year	Treatment/Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. When was the last time you had a full physical exam? _____ Pap smear? _____

_____ _____

Patient Signature Date