Women's Health Medical History Form

Personal Information

Full Name

Date of Birth

Phone Number

Email

Address

Medical History

Are you currently under a doctorâ€™s care?

Yes No

If yes, please explain

List any medications you are currently taking

List any allergies

Have you had any surgeries?

Yes No

If yes, please specify

Family History of Medical Conditions

Gynecological History

Age of first period

Date of last period

Are your periods regular?

Yes No

Any significant menstrual symptoms?

Contraceptive method used (if any)

Have you ever been pregnant?

Yes No

If yes, number of pregnancies

Number of live births

Other Information

Additional concerns or information