



Kathy E Wolf MD PC

Bringing hope through compassionate healthcare

Name: _____

DOB _____

Date _____

Personal Medical History

Please list allergies: _____

List all medications including over the counter medicines: _____

Past Medical History

(Please circle and use the line follow for description)

Migraine Headaches Yes No Date of onset: _____

Have you had a workup by an internist or neurologist? Yes No

Thyroid disease Yes No _____

Breast disease such as tumors, lumps, cysts, or discharge Yes No

Diabetes Yes No If yes, Type 1 or Type 2 Date/Age of Onset _____

High Blood Pressure Yes No

Heart disease such as:

heart attack Yes No If yes, date of occurrence _____

heart murmur Yes No

If yes, do you take antibiotics at the dentist office or before surgery? _____

rheumatic fever Yes No

stroke Yes No

high cholesterol Yes No

blood clot in extremities or lungs Yes No

Lung disease Yes No _____

Kidney disease or stones Yes No _____

Urinary tract infections Yes No _____

Liver disease Yes No _____

Gall bladder disease Yes No

Blood disease

sickle cell anemia Yes No

clotting problems Yes No

Bleeding disorders Yes No

Cancer Yes No

If Yes, what type _____ Diagnosed when _____

Depression: Yes No Anxiety: Yes No Other mental health disorders _____

Other Medical History _____

Gynecological History

Age at first menstrual period _____ Periods occur every _____ days and last for _____ days.
Date of the first day of your last menstrual period _____ Any bleeding in between? _____
If you are in menopause, date/age at which your periods stopped _____
Are you sexually active? Yes No If No, have you ever been sexually active? _____
How many sexual partners have you had within the last 5 years? _____
Do you have a female partner? _____
What method do you use to keep from getting pregnant? None Natural Family Planning
Condoms Diaphragm Birth control pills IUD Tubal ligation/Essure Vasectomy
Date of last pap smear _____
Have you ever had an abnormal pap smear? Yes No
Have you ever had a colposcopy for an abnormal pap? Yes No If yes, date _____
Have you ever had cryosurgery, a cone biopsy, or a LEEP procedure? Yes No
If yes, date of procedure _____
Have you ever had a sexually transmitted disease? Yes No Gonorrhea Syphilis
Herpes Chlamydia Warts Human Papilloma Virus(HPV) HIV Trichomonas Other
Have you had the HPV vaccine? _____ If yes, did you receive all three doses? _____
Do you have: endometriosis uterine fibroids PCOS PMS Ovarian cysts

Pregnancy History

Number of pregnancies _____ Number of living children _____ Age of Children _____
Have you ever had:
miscarriage Yes No abortion Yes No
ectopic pregnancy Yes No cesarean section Yes No
Did you have problems during pregnancy? _____
Do you plan more children in the future? Yes No

Surgical/Hospital History

Please list any hospitalizations or surgeries and dates: _____

Family History

Has anyone in your family had: (Please name who and age at diagnosis, if you know.)

High blood pressure	Yes	No	_____
High cholesterol	Yes	No	_____
Heart Attack	Yes	No	_____
Stroke	Yes	No	_____
Breast cancer	Yes	No	_____
Ovarian cancer	Yes	No	_____
Colon cancer	Yes	No	_____
Uterine cancer	Yes	No	_____
Osteoporosis	Yes	No	_____
Diabetes	Yes	No	_____
Blood clot in lungs or extremities	Yes	No	_____

Tested positive for the breast cancer gene Yes No _____

Did your mother take DES while pregnant with you? Yes No

Father Living Deceased If deceased, cause of death _____ age _____

Mother Living Deceased If deceased, cause of death _____ age _____

Siblings Living Deceased If deceased, cause of death _____ age _____

Social History

Are you: Single Married Occupation: _____

Do you smoke? Yes No If yes, how many cigarettes/day _____

Do you use alcohol? Yes No If yes, how many drinks/week _____

Do you use street drugs? Yes No If yes, which ones _____