GREAT LAKES GYNECOLOGY AND AESTHETIC CENTER
PATIENT HISTORY

DATE: _____

NAME: _____ DATE OF BIRTH: _____

REASON FOR OFFICE VISIT:

_____

_____

_____

NUMBER OF PREGANCIES:_____ NUMBER OF BIRTHS: _____

LAST MENSTRUAL PERIOD: _____ LATEX ALLERGY: YES_____ NO___

MEDICATION ALLERGIES:

_____

_____

_____

PREVIOUS SURGERIES:	DATE:

MEDICATIONS:	HERBAL SUPPLEMENTS OR VITAMINS: