WOMEN'S MEDICAL CENTER, P.C.

HISTORY

DATE_____/_____/_____

NAME_____Date of Birth _____/_____/_____ AGE_____

DO YOU HAVE A REGULAR (FAMILY) DOCTOR? ❑ NO ❑ YES IF YES, WHO? _____

WITH WHOM DO YOU LIVE?_____ANY PETS? ❑NO ❑ YES IF YES, TYPE? _____

OCCUPATION (OR FORMER JOB IF UNEMPLOYED OR RETIRED)_____

DO YOU SMOKE/ USE ANY NICOTINE PRODUCTS? ❑ NO ❑ YES IF YES, HOW MUCH? _____

HAVE YOU SMOKED REGULARLY IN THE PAST? ❑ ❑ NO ❑ YES FOR HOW MANY YEARS? _____

DO YOU DRINK ALCOHOL? ❑ NO ❑ YES AVG # OF DRINKS _____PER WEEK/DAY/MO

DO YOU USE RECREATIONAL DRUGS? ❑ NO ❑ YES IF YES, TYPE?_____

ALLERGIES& REACTIONS (FOOD, DRUG & ENVIRONMENTAL):_____

_____

CURRENT MEDICATIONS, VITAMINS & HERBALS _____

_____

_____

SEXUALLY ACTIVE? ❑ YES ❑NOT CURRENTLY ❑ NEVER ANY PROBLEMS WITH SEX LIFE? ❑ NO ❑ YES

IF YES, SEXUAL ORIENTATION? ❑ HETEROSEXUAL ❑HOMOSEXUAL (LESBIAN OR GAY) ❑ BISEXUAL

OF SEX PARTNERS(in your lifetime)_____AGE AT FIRST INTERCOURSE?_____

DATE LAST PERIOD BEGAN: _____AGE PERIODS BEGAN_____DURATION (# of days of bleeding)_____

INTERVAL OF CYCLE (start of one period to start of next)_____

USUAL FLOW: ❑ LIGHT ❑ MODERATE ❑ HEAVY SANITARY PROTECTION? ❑ PADS ❑ TAMPONS ❑ BOTH

PAIN: ❑ NONE ❑ MILD ❑ MODERATE ❑ SEVERE SPOTTING/BLEEDING BETWEEN PERIODS? ❑ NO ❑ YES

DATE OF LAST PAP SMEAR_____ANY PREVIOUSLY ABNORMAL PAPS? ❑ NO ❑ YES

CURRENT METHOD OF BIRTH CONTROL_____ PROBLEMS? _____

PRIOR METHOD OF BIRTH CONTROL_____ PROBLEMS? _____

ANY PROBLEMS WITH LEAKAGE OR BLADDER CONTROL? ❑ NO ❑ YES

EVER HAD:

A MAMMOGRAM? ❑ NO ❑ YES DATE OF LAST ONE? _____

A BONE DENSITY? ❑ NO ❑ YES DATE OF LAST ONE? _____

A COLONOSCOPY? ❑ NO ❑ YES DATE OF LAST ONE? _____

PLEASE FILL OUT OTHER SIDE!

PREGNANCIES: (INCLUDING MISCARRIAGES, ABORTIONS & TUBAL PREGNANCIES)

NO.	YEAR	SEX	WEIGHT	COMPLICATIONS (LABOR/DELIVERY/MISCARRIAGE)	HEALTH (child)
1					
2					
3					
4					
5					
6					

PAST HEALTH

HAVE YOU EVER HAD	NO	YES	IF YES, PLEASE EXPLAIN
CANCER			
HIGH BLOOD PRESSURE			
DIABETES			
THYROID PROBLEMS			
ASTHMA/PNEUMONIA/TUBERCULOSIS			
HEART MURMUR/ANGINA/OTHER HEART PROBLEMS			
ULCERS			
LIVER DISEASE (e.g. HEPATITIS, JAUNDICE)			
GALL BLADDER DISEASE (e.g. STONES, INFECTIONS)			
BLOOD TRANSFUSIONS			
ANEMIA			
BLOOD CLOTS IN LEGS OR LUNGS			
ARTHRITIS			
TREATMENTS FOR PSYCHO LOGIC/PSYCHIATRIC CONDITIONS (e.g. depression)			
KIDNEY/URINARY TRACT AILMENTS			
MIGRAINES, SEIZURES, OR STROKE			
GONORRHEA/CHLAMYDIA/PID			
FIBROIDS/ENDOMETRIOSIS			
HPV/GENITAL WARTS/ HERPES/SYPHILIS			
OTHER SERIOUS ILLNESS			

OPERATIONS: LIST ALL SURGERIES AND HOSPITAL STAYS

YEAR:	OPERATION/REASON FOR HOSPITALIZATION

FAMILY HISTORY (PARENTS/GRANDPARENTS/AUNTS/UNCLES/SIBLINGS

HAS ANY RELATIVE HAD	NO	YES	RELATIVE	AGE WHEN DIAGNOSED
STROKE				
HEART ATTACK OR ANGINA				
DIABETES				
BLOOD CLOTS				
CANCER- BREAST				
CANCER – UTERINE				
CANCER – COLON				
CANCER – OVARIAN				
OSTEOPOROSIS				
HIGH BLOOD PRESSURE				
ENDOMETRIOSIS				

DATE:

SIGNATURE/PRINT NAME: DATE OF BIRTH: