Patient Health History

Patient Name: _____ **Age:** _____ **Date of Birth:** _____

Family Doctor: _____ **Referred By:** _____

Reason for Visit: _____

WARSAW WOMEN'S CENTER

Past Medical History

CONDITION	CURRENT	HISTORY	NO	CONDITION	CURRENT	HISTORY	NO
Abnormal PAP Smear				Herpes			
Anemia				Human Immunodeficiency Virus (HIV)			
Anesthesia Complication				Human Papilloma Virus (HPV)			
Anxiety				Hypertension			
Asthma				Infertility			
Blood Clot in Legs or Lung				Kidney Stone			
Blood Transfusion				Liver Disease			
Breast Disorder				Lupus			
Cancer of the Breast				Migraine			
Cancer, other				Mitral Valve Prolapse			
Cardiovascular Disease				Pelvic Inflammatory Disease			
Chlamydia				Rheumatic Fever			
Depression				Seizures / Convulsions			
Diabetes				Stroke			
Endometriosis				Syphilis			
Epilepsy				Thyroid Disorder			
Fibromyalgia				Trichomoniasis			
Gonorrhea				Tuberculosis			
Heart Murmur				Ulcer			
Hepatitis B				Urinary Tract Infection			
Hepatitis C							

Date of Last Pap Smear: / / Normal Abnormal **Date of Last Mammogram: / / Normal Abnormal**

Date of Last Dexa Scan: / / Normal Abnormal **Date of Last Colonoscopy: / / Normal Abnormal**

Other:

Operations / Surgeries

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
1)		4)	
2)		5)	
3)		6)	

Medications

Include prescriptions, over-the-counter, herbals, and vitamins

MEDICATION	DOSAGE	PRESCRIBING PHYSICIAN
1)		
2)		
3)		
4)		
5)		
6)		

Medication Allergies

Latex Allergy: Are you allergic to latex? (circle) **YES** **NO**

MEDICATION	REACTION
1)	
2)	
3)	

Over, Please

Family Medical History

Do any of your children, siblings, grandparents (maternal/paternal), or parents have any of the following?

ILLNESS	YES	RELATIONSHIP	ILLNESS	YES	RELATIONSHIP
None			Cardiovascular Disease		
Adopted			Depression		
Blood Clot in Legs or Lungs			Diabetes		
Cancer, Breast			Hypertension		
Cancer, Cervical			Osteoporosis		
Cancer, Colon			Polyp - anal/rectal/colon		
Cancer, Ovarian			Stroke		
Cancer, Uterine			Thyroid Disorder		
Cancer, Other					

Genetic History / Screening

Self, partner, or other family member

CONDITION	YES	RELATIONSHIP	CONDITION	YES	RELATIONSHIP
Cats - do you have exposure?			Ingestion of uncooked meat		
Chickenpox			Patient age > 35 years as of EDC		
Congenital Heart Defect			Phenylketonuria (PKU)		
Cystic Fibrosis			Rh Sensitized		
DES Exposure			Sickle Cell Anemia		
Diabetes - Self only			Tay-Sachs Disease		
Down Syndrome			Thalassemia (Italian, Greek, Mediterranean)		
Infertility			Uterine Defect		

Reproductive History

Age of first menses:	**Cycle Interval** (Number of days from start to start):
Menses Duration (Number of days of bleeding):	**Flow (circle):** Light Medium Heavy
Number of Tampons per day:	**Number of Pads per day:**
Last Menstrual Period (Date): / /	**Certain of LMP Date? (circle):** YES NO
Menopause Status (circle): Pre Peri Post	**Age at Menopause:**
Method of Birth Control:	**Clots (circle):** YES NO
Breakthrough Bleeding (circle): YES NO	**On HRT? (circle):** YES NO

Pregnancy History

Date	Gestational Age	Hours in Labor	Birth Weight	Sex	Type of Delivery	Anesthesia	Early Labor?	Comments / Complications	Hospital

Social History

Marital Status (circle): Divorced Married Single Widowed **Spouse / Partner Name:**_____

Occupation:

Alcohol (check): Never_____ Current_____ Former_____ (If current or former) **Amount per Week**_____

Drugs (check): Never_____ Current_____ Former_____ (If current or former) **Type**_____

Smoking (check): Never_____ Current_____ Former_____ (If current or former) **Amount per Day**_____

Amount of Exercise: Active Heavy Medium Minimal None (Sedentary)