ASSOCIATES IN women's health

Patient Medical History

Patient Name: _____ DOB: _____ Age: _____

Name you prefer to be called: _____

Primary Care MD: _____ Referring MD: _____

Drug Allergies: _____ No Medication Allergies Eggs Latex Iodine

Current Contraception: _____ Date of Last annual Exam: _____

1st day of last menstrual period: _____

What concerns do you want to discuss at today's appointment? _____

_____

What symptoms do you want to talk to the provider about? _____

_____

Other physician/provider visits since last time here? (for same condition) ☐ Yes ☐ No

If yes, (who/where):

Do you have specific requests for:

☐ New Medication: _____

☐ Refills: _____

☐ Vaccinations: _____

☐ Referrals: _____

☐ Tests: _____

☐ Completion of forms: _____

☐ School or work release: _____

☐ Other: _____

Surgical History

Date Surgery MD/Hospital Complications

_____

_____

_____

_____

Obstetrical History (Including Miscarriages and Terminations)

Have you had any miscarriages? ☐ No ☐ Yes, When: _____

Have you had any terminations? ☐ No ☐ Yes, When: _____

Date Child's Sex/Name Birth Weight Labor Length Vag/Cesarean MD/Hosp Complications

_____

_____

_____

_____

Family History

Mother Living Y N Diseases: _____ ☐ None
If Yes, Age _____ If No, Cause of Death and age _____

Father Living Y N Diseases: _____ ☐ None
If Yes, Age _____If No, Cause of Death and age _____

Maternal Grandmother Living Y N Diseases: _____ ☐ None
If Yes, Age _____If No, Cause of Death and age _____

Paternal Grandmother Living Y N Diseases: _____ ☐ None
If Yes, Age _____ If No, Cause of Death and age _____

Maternal Grandfather Living Y N Diseases: _____ ☐ None
If Yes, Age _____ If No, Cause of Death and age _____

Paternal Grandfather Living Y N Diseases: _____ ☐ None
If Yes, Age _____ If No, Cause of Death and age _____

Brother/Sister (circle one) Living Y N Diseases: _____ ☐ None
If Yes, Age _____ If No, Cause of Death and age_____

Brother/Sister (circle one) Living Y N Diseases: _____ ☐ None
If Yes, Age _____ If No, Cause of Death and age_____

Brother/Sister (circle one) Living Y N Diseases: _____ ☐ None
If Yes, Age ____ If No, Cause of Death and age_____

Brother/Sister (circle one) Living Y N Diseases: _____ ☐ None
If Yes, Age ____ If No, Cause of Death and age_____

Past Illnesses

Have you experienced any of the following:

AIDS/HIV	Asthma	Cancer	Stroke	Diabetes	Heart Disease	Ulcers
Thyroid problems	Phlebitis	Seizures	Arthritis	Diverticulosis	Kidney infection	Gonorrhea
Chlamydia	Herpes	Genital warts				

Personal/Family History

Have you or any close members of your family including grandparents, aunts and/or uncles had any of the following medical conditions?

	Patient	Family	Relationship	Age Diagnosed
Breast Cancer	☐	☐		
Ovarian Cancer	☐	☐		
Endometrial Cancer	☐	☐		
Colon Cancer	☐	☐		
Colon Polyps	☐	☐		
Ulcerative Colitisure	☐	☐		
Heart Disease/Angina	☐	☐		
Elevated Cholesterol	☐	☐		
Osteoporosis	☐	☐		
Broken Hip/Spine	☐	☐		
Diabetes	☐	☐		
Kidney Disease	☐	☐		
Thyroid Disease	☐	☐		
Lupus	☐	☐		
Mental Illness	☐	☐		
Substance Abuse	☐	☐		
Blood Clots/Thrombosis	☐	☐		
Problems w/Anesthesia	☐	☐		

Menstrual History

Age at onset: _____ Frequency _____ Days of flow _____ Heavy flow
Menopause: Age _____

Social History

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Separated
Number of children living? _____
Special diet? ☐ No ☐ Weight Loss ☐ Low Fat ☐ Vegan ☐ Diabetic ☐ Vegetarian
Exercise? ☐ None ☐ Routine of _____
Do you do monthly breast exams? ☐ Yes ☐ No
Calcium intake? ☐ 0-1 servings daily ☐ 2-3 servings daily ☐ Supplements
Are you employed? ☐ Yes ☐ No Where _____ Position _____
Do you smoke? ☐ No ☐ Yes Frequency/Quantity _____
Do you drink alcohol? ☐ 0 ☐ Infrequent ☐ 1-4 ☐ 5-8 ☐ 10-12 ☐ 13+ average drinks per week
Do you use street drugs? ☐ No ☐ Yes ☐ Marijuana ☐ Other Frequency/Quantity_____
Is anyone physically or emotionally hurting you? ☐ No ☐ Yes, Who?_____
Are you sexually active? ☐ Yes ☐ No
Do you have multiple sexual partners? ☐ No ☐ Yes, # in last year? _____

Vaccinations

Have you been immunized against the following? Include dates if possible.
Measles _____ Mumps _____ Rubella _____ Tetanus _____
Chickenpox _____ Polio _____ Hepatits B _____ Hepatitis A _____
Have you had a TB test? ☐ No ☐ Yes, Year _____ Result _____

Please check if you are now or recently experiencing any of the following:

Constitutional: ☐ Anorexia/Bulemia ☐ Weight loss ☐ Weight gain ☐ Fatigue ☐ Sweating ☐ Fever
Eyes: ☐ Vision loss ☐ Double vision ☐ Spots
Ear/Nose/Throat: ☐ Ringing in ear ☐ Earache ☐ Sore throat ☐ Bleeding gums ☐ Congestion
Cardiac: ☐ Chest pain ☐ Palpitations ☐ Swelling (location _____)
Respiratory: ☐ Wheezing ☐ Cough ☐ Shortness of breath
GI: ☐ Constipation ☐ Diarrhea ☐ Bloating ☐ Black or bloody stools
GU: Urine: ☐ Frequency ☐ Urgency ☐ Burning ☐ Incontinence ☐ Pain
Periods: ☐ Cramps ☐ Irregular ☐ Heavy ☐ Spotting ☐ PMS
Vagina: ☐ Dryness ☐ Itching ☐ Discharge ☐ Painful ☐ Intercourse
Menopause: ☐ Hot flashes ☐ Night sweats ☐ Other _____
Muscle: ☐ Joint pain ☐ Muscle cramps ☐ Weakness
Skin: ☐ Rash ☐ Dryness ☐ Lesions ☐ Acne ☐ Moles
Breast: ☐ Lump ☐ Discharge ☐ Pain ☐ Skin changes
Neuro: ☐ Headaches ☐ Dizziness ☐ Tremors ☐ Weakness ☐ Seizures
Psych: ☐ Depression ☐ Anxiety ☐ Insomnia ☐ Memory loss ☐ Moodiness
Endo: ☐ Excess thirst ☐ Hair loss ☐ Excess hair ☐ Cold/heat intolerance ☐ Excess urination
Lymph: ☐ Bruising ☐ Nosebleeds ☐ Swollen glands

Please list current ***PRESCRIBED*** medications you are taking along with the strength and dose.

Medication	Strength	Dose

Please list current ***OVER THE COUNTER*** medications you are taking along with the strength and dose.

Medication	Strength	Dose

SIGNATURE: _____ ***DOB:*** _____ ***DATE:*** _____