

# Women's Healthcare Associates, LLC

## REVIEW OF MEDICAL HISTORY

Please answer the following questions

Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

By what name do you like to be called? \_\_\_\_\_ Do you want a female attendant in the room during your exam? Y N

Current Reason for Visit \_\_\_\_\_

Referred by \_\_\_\_\_

Marital history:  Single  Divorced  Married  Domestic Partner  Name of partner, if applicable \_\_\_\_\_

### Allergies

Do you have any allergies to medications?  YES  NO If so, please list here \_\_\_\_\_

Other \_\_\_\_\_

### Habits/Exposures

Do you smoke?  YES  NO How many packs per day? \_\_\_\_\_ How many years have you smoked? \_\_\_\_\_

Do you drink alcohol?  YES  NO If so, how much per day? \_\_\_\_\_ Quit for pregnancy?  YES  NO

Other Drugs  X-rays this pregnancy HIV discussed  YES  NO Other \_\_\_\_\_

Are you currently taking any medication?  YES  NO If so, please list regular meds. taken (including over the counter drugs) \_\_\_\_\_

Did your mother ever take any medication to prevent miscarriage when she was pregnant with you?  YES  NO

### Menstrual History

What was the date of the first day of your most recent period? \_\_\_\_\_  or onset of menopause? \_\_\_\_\_ year

How many days do you flow? \_\_\_\_\_ How heavy do you flow? \_\_\_\_\_

How many days from the first day of one period to the first day of the next? \_\_\_\_\_ Are your periods painful?  YES  NO

Do you have abnormal bleeding  YES  NO Do you have PMS symptoms?  YES  NO

How old were you when you had your first period? \_\_\_\_\_ When was your last Pap Smear? \_\_\_\_\_

Have you ever had an Abnormal Pap?  YES  NO When was your last Mammogram? \_\_\_\_\_

### Sexual History

Are you currently sexually active with anyone?  YES  NO  Male  Female  Both Male and Female

Do you have pain with sexual activity?  YES  NO Do you feel satisfied with your sexual experiences?  YES  NO

Do you have a sexual issue to discuss?  YES  NO \_\_\_\_\_

Do you have any history of sexual abuse?  YES  NO Has anyone hurt you or hit you in the past year?  YES  NO

Do you use any method of contraception including vasectomy, condoms or tubal ligation?  YES  NO

If so, what kind? \_\_\_\_\_

What have you used in the past for birth control? \_\_\_\_\_

Do you have a history of pelvic inflammatory disease?  YES  NO

Do you have any history of sexually transmitted disease? (please circle) chlamydia, gonorrhea, herpes, or genital warts?

### Obstetrical History

How many times have you actually been pregnant? \_\_\_\_\_ How many living children do you have? \_\_\_\_\_

No.	Date	Gestation Length	Labor Hours	Type Delivery	Anesth.	Sex	Wt.	PLACE OF DELIVERY	Baby's Name	Complications

Have you ever had a history of drug use?  YES  NO If so, please list what drugs \_\_\_\_\_

Are you currently seeing a therapist?  YES  NO If yes, who do you see? \_\_\_\_\_

Have you ever received medication for depression?  YES  NO If yes, what was it? \_\_\_\_\_

Do you have any other issues you wish to discuss?  YES  NO Please list here \_\_\_\_\_

### **Hospitalizations**

*Please list date and nature of hospitalization below.*

#### **Operations**

#### **Hospitalization for illness or injury**

1) \_\_\_\_\_ 1) \_\_\_\_\_

2) \_\_\_\_\_ 2) \_\_\_\_\_

3) \_\_\_\_\_ 3) \_\_\_\_\_

Do you have any chronic or serious illnesses?  YES  NO

If yes, please list \_\_\_\_\_

### **General Physical Condition or Problems**

*Do you have any problems with any of the following? If yes, please list below.*

Hearing, Eyes, Ears, Nose, Throat  YES  NO Hepatitis or any kind of liver ailment or jaundice  YES  NO

Heart problems or high blood pressure  YES  NO Kidney or bladder problems/leaking of urine  YES  NO

Lung problems/Asthma/Bronchitis  YES  NO Anemia/blood disorder/transfusion  YES  NO

Breast lumps/pain/nipple discharge  YES  NO Thyroid problems/diabetes/other endocrine problems  YES  NO

Stomach/bowel/gall bladder problems  YES  NO Headaches/migraines/nervous disorder  YES  NO

Varicose veins or phlebitis  YES  NO Chicken Pox  YES  NO

Other \_\_\_\_\_

### **Family History**

*Who in your family have any of the following?*

High Blood Pressure  YES  NO \_\_\_\_\_ Breast Cancer or Breast Disease  YES  NO \_\_\_\_\_

Stroke  YES  NO \_\_\_\_\_ Colorectal cancer  YES  NO \_\_\_\_\_

Heart Problems  YES  NO \_\_\_\_\_ Ovarian cancer  YES  NO \_\_\_\_\_

Kidney Problems  YES  NO \_\_\_\_\_ Hepatitis/TB/or any other infectious disease  YES  NO \_\_\_\_\_

Diabetes  YES  NO \_\_\_\_\_ Other \_\_\_\_\_

### **Genetic History**

*Please complete if you are pregnant or contemplating pregnancy in the future.*

Do you know of any family history of genetic disorders or birth defects?  YES  NO

Do you know of any family history of the following abnormalities? If yes, please tell us the relationship.

Sickle Cell Anemia  YES  NO Fragile X  YES  NO Hemophilia  YES  NO

Thalassemia  YES  NO Cystic Fibrosis  YES  NO Spinal Bifida  YES  NO

Tay-Sachs Disease  YES  NO Huntington's Chorea  YES  NO Cleft Lip/Palate  YES  NO

Down's Syndrome  YES  NO Muscular Dystrophy  YES  NO Chromosomal problem  YES  NO

Is there any family history of developmental delay?  YES  NO

Please list any concerns you may have regarding pregnancy or future pregnancy \_\_\_\_\_

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