WOMEN'S HEALTHCARE ASSOCIATES LLC

Name (please print):

_____

Date of Birth: _____

Reason for Visit: _____

Last Menstrual Period: _____

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Medical History

Check any of the following medical conditions that you currently have or have had in the past:

- ☐ Abnormal Heart Rhythm
- ☐ Anemia
- ☐ Anesthetic Complications
- ☐ Anxiety
- ☐ Asthma
- ☐ Autoimmune Condition
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Blood Transfusions
- ☐ Brain Injury/Problem
- ☐ Cancer
  Type:_____
- ☐ Depression
- ☐ DES Exposure
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Endometriosis
- ☐ Eye/Ear Problems
- ☐ Fibromyalgia
- ☐ Frequent Bladder Infections
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Infertility
- ☐ ITP/Platelet Disorder
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver/Gallbladder Problems
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Nose/Mouth/Throat Problems
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Ovarian Cysts
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Premenstrual Syndrome (PMS/PMDD)
- ☐ Psychiatric Care
- ☐ Respiratory Disease
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Sleeping Problems
- ☐ Stomach/Bowel Problems
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Ulcerative Colitis/Crohn's Disease
- ☐ Urinary/Fecal Incontinence
- ☐ Uterine Fibroids
- ☐ Other: _____

Surgical History

Have you had any of the following surgeries? (*Check all that apply*)

- ☐ Abnormal Pap/Cervical Dysplasia Surgery
- ☐ Abnormal Uterine Bleeding Surgery
- ☐ Appendectomy
- ☐ Brain Surgery
- ☐ Breast Augmentation
- ☐ Breast Biopsy/Lumpectomy
- ☐ Breast Reduction
- ☐ Cerclage Placement
- ☐ Cesarean Section
- ☐ Endometriosis Surgery
- ☐ Eye Surgery
- ☐ Fibroid Removal
- ☐ Gallbladder Removal
- ☐ Heart Surgery
- ☐ Hysterectomy
- ☐ Hysteroscopy
- ☐ Kidney/Bladder Surgery
- ☐ Laparoscopy
- ☐ Mastectomy
- ☐ Nose/Mouth/Throat Surgery
- ☐ Orthopedic (Bone/Joint) Repair
- ☐ Ovarian Surgery
- ☐ Plastic/Reconstructive Surgery
- ☐ Spine Surgery
- ☐ Stomach/Bowel Surgery
- ☐ Tubal Ligation
- ☐ Urine Leakage Surgery
- ☐ Other: _____

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Family History

Check any of the following conditions that a family member currently has or has had in the past, then indicate who in your family has/had the condition.

- ☐ Alcoholism _____
- ☐ Anesthetic Complications _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Birth Defects _____
- ☐ Bleeding Disorder _____
- ☐ Blood Clots _____
- ☐ Breast Cancer _____
- ☐ Cervical Cancer _____
- ☐ Colon Cancer _____
- ☐ Colon Polyps _____
- ☐ Depression _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Kidney Disease _____
- ☐ Lung Cancer _____
- ☐ Osteoporosis _____
- ☐ Ovarian Cancer _____
- ☐ Pancreatic Cancer _____
- ☐ Psychiatric Care _____
- ☐ Respiratory Disease _____
- ☐ Seizures _____
- ☐ Stroke _____
- ☐ Skin Cancer _____
- ☐ Stroke _____
- ☐ Thyroid Disease _____
- ☐ Uterine Cancer _____
- ☐ Other _____

Tobacco & Alcohol Use

Do you use tobacco products? ☐ I never have ☐ I currently do ☐ I used to, but quit in _____

If you currently use or used to use tobacco products, when year did you begin using them? _____

What type(s) do you currently use/did you used to use?

☐ Cigarettes; indicate packs/day _____ ☐ Cigars ☐ Other: _____

Are you exposed to second hand smoke? ☐ No ☐ Yes

Do you use alcohol? ☐ No ☐ Yes

If yes, how many drinks per day do you consume? _____ What type(s) of alcohol do you consume? _____

Sexual History

Are you sexually active? ☐ Yes, with men ☐ Yes, with women ☐ Yes, with men and women ☐ No

What type(s) of contraception do you currently use? _____

What methods of contraception have you used in the past? _____

Have you ever had a sexually transmitted disease? ☐ No ☐ Yes

If yes, please indicate type(s): ☐ Gonorrhea ☐ Chlamydia ☐ Genital warts ☐ Herpes ☐ Hepatitis B ☐ Trichomonas ☐ Syphilis ☐ Hepatitis C

Menstrual History

How old were you when you first had your period? _____

How many days does your period last? _____

How many days from the first day of one period to the first day of the next? _____

How would you describe your flow? ☐ Normal ☐ Light ☐ Spotting only ☐ Heavy ☐ Heavy with clots ☐ Heavy with flooding

How would you describe the regularity of your cycle?

☐ Regular ☐ Spotting between periods ☐ Bleeding between periods

Miscellaneous

Do you use any illicit substances? ☐ No ☐ Yes If yes, which ones do you use? _____

Do you have any of the following risk factors? (*Check all that apply*)

☐ IV drug use ☐ Multiple blood transfusions ☐ Partner with HIV

☐ Partner with Hepatitis B ☐ Partner with Hepatitis C

How many caffeinated beverages do you consume each day? _____

How many times per week do you exercise? _____ Type(s) of exercise: _____

Do you feel safe at home? ☐ No ☐ Yes

Are you currently being hit, punched, kicked, or slapped by anyone? ☐ No ☐ Yes

Do you need to discuss violence at home with your provider? ☐ No ☐ Yes

Preventive Care

When was your last Pap smear? _____

Have you had an abnormal Pap smear in the last 5 years? ☐ No ☐ Yes

Have you had cervical dysplasia in the past 5 years? ☐ No ☐ Yes

When was your last mammogram? _____

Medications (note name, dose, and instructions)

_____

_____

_____

_____

_____

_____

_____

Allergies

☐ No known allergies

_____

_____

_____

_____

_____

Obstetric History

How many pregnancies have you had? _____

How many living children do you have? _____

How many of your deliveries were full term (after 37 weeks)? _____

How many of your deliveries were premature (20-37 weeks)? _____

How many c-sections have you had? _____

How many miscarriages have you had? _____

How many elective abortions have you had? _____

How many ectopic/tubal pregnancies have you had? _____

How many sets of twins or triplets have you had? _____

Have you had any complications during past pregnancies? ☐ No ☐ Yes

If yes, please mark all complications:

☐ Breech ☐ Bleeding ☐ Premature labor ☐ High blood pressure ☐ Premature delivery

☐ Gestational diabetes ☐ Premature rupture of membranes ☐ Other _____