

Women's Health Care Group of PA

Patient Medical History

Please complete the following information as accurately as possible. Your answers on this form will help your provider understand your medical concerns and conditions better. If you cannot remember specific details, please give best estimates. We realize that this a very lengthy form, but we are asking you to provide a comprehensive history for our Electronic Medical Record which results in improved care for you.

Name: _____ DOB: _____ Date: _____

Marital Status: Single Married Widowed Divorced Domestic Partner SS# _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander
 Other Race White Unknown Declined

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Unknown Declined

Preferred Method Of Communication: Phone Mail E-mail Text

Email: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Pharmacy Name: _____ Phone: _____ Fax: _____

Reason for Visit:

What is the reason for your visit: Annual exam Obstetric first visit Gyn Problem

If you are here for a problem what are your concerns? _____

Health Maintenance Screening Tests:

Colonoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date ___/___/___	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Dexa Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date ___/___/___	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Mammogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date ___/___/___	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

Pap Smear History:

Pap smear	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date ___/___/___	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
LEEP	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date ___/___/___	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Colposcopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date ___/___/___	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
History of HPV?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date ___/___/___			
Received HPV vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date ___/___/___	<input type="checkbox"/> Inj.1	<input type="checkbox"/> Inj.2	<input type="checkbox"/> Inj.3

Personal Medical History: Check if you had any of these medical problems in the past.

Major illness	Yes	Major Illness	Yes
Anemia		Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
Anxiety		High blood Pressure	
Arthritis/Joint Pain		High Cholesterol	
Asthma		Hypothyroid	
Blood clot/DVT		Hyperthyroid	
Blood Transfusions		Interstitial Cystitis	
Breast Cancer		IBS (irritable bowel syndrome)	
Cancer- list type:		Jaundice	
Chronic Lung Disease		Migraines	
Depression		Osteopenia	
Diabetes Type1		Osteoporosis	
Diabetes Type 2		Ovarian Cancer	
Fibroids		Seizures	
Fracture		Sexually Transmitted Disease	
GERD		Stroke	
Heart Disease		Tuberculosis-TB	

Other: _____

Past Surgical History: No past surgical history

Year	Surgery	Complications?

Current Medications: None If there is not sufficient space please attach copy of medications list to this form.

Prescription and non-prescription medicine, vitamins, home remedies, birth control pills, herbs:

Medication	Dosage (mg)	Frequency	Prescribing Physician

Allergies: (Food, Drugs, Environmental) None Latex Iodine

Allergy	Interaction	Allergy	Interaction

Family Medical History: Please indicate below significant medical problems of family members. Indicate which family member by checking the appropriate column and the AGE OF ONSET: No Family History Adopted

	None	Mother	Father	Brother	Sister	Grand Mother (Maternal)	Grand Mother (Paternal)	Grand Father (Maternal)	Grand Father (Paternal)	Aunt	Uncle
Blood Clots/DVT											
Breast Cancer											
Cervical Cancer											
Colon Cancer											
Diabetes											
Ovarian Cancer											
Hypertension											
Stroke											
Uterine Cancer											
Other Cancers not mentioned											
Other disease's not mentioned											

Genetic Screening: None Includes patient, baby's father, or anyone in either family

Indicate Yes or No	Yes	No		Yes	No
Tay-Sachs			Sickle Cell Disease or Trait		
Neural Tube Defect			Maternal Metabolic Disorder		
Other inherited Genetic or chromosomal Disorder			Mental Retardation/Autism		
Thalassemia			Medication/Street Drugs/Alcohol		
Hemophilia			Muscular Dystrophy		
Cystic Fibrosis			Huntington Chorea		
Down Syndrome			Congenital Heart defect		
Patient or father of the baby had/has a child with birth defects not listed			Recurrent pregnancy loss or a still birth		

Gynecology:

Age at first period:	1 st day (date) of last period:
Frequency of period:	Describe Period: <input type="checkbox"/> Light <input type="checkbox"/> Normal <input type="checkbox"/> Heavy
Length of period:	Current Contraceptive Method:
Do you have concerns regarding your period? describe:	Are you in menopause? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last period: Are you on hormone replacement therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No

Obstetrics:

	Number			Number			
Total number of pregnancies			Abortions Induced				
Full Term Births			Miscarriages				
Pre-Term Births			Living Children				
No.	Birth Date	#weeks at delivery	Sex	Birth Weight	Delivery Type	Complications	Location of Delivery
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

Social History

Are you currently sexually active? Yes No ____ If yes, what age did you become sexually active? _____

Current sexual partner (s) is/are: Male Female Male and Female _____

Have you had more than 5 sexual partners in a lifetime? Yes No If yes, how many? _____

Have you ever has any sexually transmitted diseases?(STDs): Yes No

If yes, what kind? _____

Are you interested in STD screening? Yes No

Do you drink alcohol? Yes No If yes, Social Drinker Daily if yes, how many drinks per week? _____

Do you use recreational drugs? Yes No If yes, what kind? _____

Do you use tobacco? Yes No If yes, Current every day _____ Current some days _____

Former _____ Never _____

If current, how many cigarettes a day? _____ if an occasional smoker – please describe: _____

Life Style: Please check off answer and give detail if it applies:

Have you been a victim of abuse or domestic violence? Yes No

Do you feel safe at home? Yes No

Do you live alone? Yes No

Do you perform self -breast exam? Yes No

Do you drink milk or consume dairy products daily? Yes No

Do you take calcium tablets? Yes No

Do you exercise? Yes No If yes, frequency - how many times a week? _____

Are you satisfied with your weight? Yes No

Please add any additional information:

AUTHORIZATION AND RELEASE:

I hereby certify that I have completed the above information to the best of my knowledge. I authorize, consent, request, and agree to actively participate in such services as routine assessments, the performance of diagnostic tests and procedures, care and treatment as self-referred or as ordered by my physician, his/her assistant or designees.

Signature

Date

Please mail or fax your completed form to our office prior to your appointment. If you cannot return your form prior to your appointment, you must arrive 30 minutes early so we can enter your information into the computer. Thank you for your attention and cooperation.