Patient Medical History

Accent On Women's Health

NAME:

DOB:

Today's Date: ____________________

Medical History: Check box if you have ever had any of the following:

- ☐ Asthma
- ☐ Anemia
- ☐ Arthritis
- ☐ Anorexia
- ☐ Bulimia
- ☐ Chronic Bronchitis
- ☐ Clotting Disorder
- ☐ COPD
- ☐ Diabetes Type______
- ☐ Anxiety
- ☐ Depression
- ☐ Emphysema
- ☐ Fractures__________
- ☐ Gallstones
- ☐ GERD
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ PCOS
- ☐ Endometriosis

- ☐ Heart Murmur
- ☐ Headaches
- ☐ Migraines
- ☐ Neuropathy
- ☐ Heart Disease___________
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Hepatitis__________
- ☐ Hemorrhoids
- ☐ High Blood pressure
- ☐ High Cholesterol
- ☐ HIV positive/ AIDS
- ☐ Irritable Bowel Syndrome
- ☐ Infertility
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Osteoporosis
- ☐ Stroke

- ☐ Tuberculosis
- ☐ PTSD (cause)_________________
- ☐ Substance Abuse(type)_____________
- ☐ Varicella (chicken pox)
- ☐ MRSA (year)____________
- ☐ DVT (blood clot/disorder)
- ☐ Pulmonary Embolism _____
- ☐ Seizure (date of last episode) __________
- ☐ Other_______________
- ☐ Cancer Type:_________ Treatment___________
- ☐ NONE

Personal Surgical History: Have you ever had any of the following surgeries? (Check if yes and list year of surgery)

- ☐ Wisdom teeth removal______
- ☐ Cesarean Section _______
- ☐ Dilation and Curettage_______
- ☐ Cholecystectomy (gallbladder)_______
- ☐ Bariatric Surgery______
- ☐ Bladder Surgery ______
- ☐ Back Surgery _______
- ☐ Breast Augmentation ______
- ☐ Breast Implant______
- ☐ Breast Reduction _______
- ☐ Appendectomy______
- ☐ Endometrial Ablation________
- ☐ Diagnostic Laparoscopy________
- ☐ Tonsillectomy________

- ☐ Colon Surgery _______
- ☐ Coronary Artery Bypass Graft ______
- ☐ Carpal Tunnel________
- ☐ Esophagus Surgery _______
- ☐ Gastric Bypass Surgery _______
- ☐ Hemorrhoid Surgery ________
- ☐ Hernia Repair _______
- ☐ Hysterectomy _______
- ☐ Kidney Surgery _______
- ☐ Neck Surgery _______
- ☐ Tubal Ligation_______
- ☐ Thyroid Surgery________
- ☐ Oophorectomy (circle one) Right Left _______
- ☐ No Surgical History

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Social History: Check all that apply

Alcohol use -	☐ Never	☐ Occasionally	☐ Daily Type: _______________
Tobacco use -	☐ Never	☐ Previously, but quit	☐ Packs Per Day ______________
Drug use -	☐ Never	☐ Occasionally	☐ Daily Type:________________
Marijuana use -	☐ Never	☐ Occasionally	☐ Daily

Do you drink caffeinated beverages? (Ex: coffee, tea, energy drinks, soda, etc.)

- ☐ I don't drink caffeinated beverages
- ☐ 1 a week
- ☐ 1-2 a day
- ☐ 3+ a day

What is your occupation/school? ____

Who is your primary care physician? ____

Who do you live with? ____

Marital Status: Single In Relationship Married Divorced Widowed

Name of spouse or significant other ________________________________

Medications/Vitamins: Please list all current:

Medication	Dose	How often do you take this medication?

Allergies:

Medications or other	Reaction

Allergy to Latex? Yes No

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Gynecological History:

Last Pap smear _____________
Last Mammogram_____________
Last Bone Density (DEXA) _____________
Last Colonoscopy _____________
Have you ever been on hormone replacement therapy (estrogen/progesterone)? Yes No

Any personal history of:
Abnormal Mammogram: Yes No (If yes what type of follow up?)_______________________
Abnormal Pap Smears: Yes: ______________________ or No
History of HPV (Human papilloma virus) Yes No
HPV vaccination series completed? Yes No Unsure
Colposcopy: Yes No If yes what year__________
Cryosurgery: Yes No If yes what year__________
Loop electrosurgical excision procedure (LEEP): Yes No If yes what year__________
Sexually transmitted diseases: No / Yes (if yes please circle)
Chlamydia, Gonorrhea, Trichomonas, Genital Warts, Syphilis, Herpes: cold sores or genital, Hepatitis, Other:____

Obstetrical History: Please record the number of:

Pregnancies _____ Live Births _____ Vaginal Births _____ C- sections _____

Ectopic _____year:_____ Elective Abortion _____ year:_____ Miscarriages _____ year:_____

Menstrual History:
First day of last menstrual period _____________
Age at first menstrual period _____________
Number of days from the start of one period to the start of the next _____________
Number of days that you bleed _____________
Describe the amount of menstrual flow (circle one) light / moderate / heavy / clots
Do you bleed in between your periods? _____________
If you stopped menstruating, at what age did you stop? _____________
Have you had bleeding or spotting since your periods stopped? _____________

Contraceptive and Sexual History:
Have you ever been sexually active? ____________
Are you currently in a sexual relationship? ___________
Number of sexual partners in the last year ___________
Present birth control method (Pills, Condoms, Withdrawal method etc.)_________________
Birth control methods used in the past ____

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Family History: Please list blood relatives that have had any of these conditions. (Parents, maternal and paternal grandparents, siblings, maternal and paternal aunts and uncles)

Asthma	Arthritis
COPD	Diabetes
Emphysema	HIV
Heart Disease	Hepatitis
Hypertension	Kidney Disease
Migraines	Kidney Stones
Bipolar	Twins
Depression	Stroke
Anxiety	Osteoporosis
Personality disorder	Genetic Disease
Schizophrenia	PCOS
Substance Abuse (type)	Endometriosis
Clotting Disorders	Tuberculosis
Thyroid	Other:

Family Cancer History: Please list blood relatives that have had any of these conditions. (Parents, maternal and paternal grandparents, siblings, maternal and paternal aunts and uncles)

Bone Cancer	Brain Cancer
Breast Cancer	Cervical Cancer
Colon Cancer	Gallbladder Cancer
Heart Cancer	Large Intestine Cancer
Laryngeal Cancer	Leukemia
Liver Cancer	Mouth Cancer
Ovarian Cancer	Pancreatic Cancer
Prostate Cancer	Skin Cancer
Small Intestine Cancer	Stomach Cancer
Testicular Cancer	Thyroid Cancer
Uterine Cancer	Kidney Cancer
Lung Cancer	Lymphoma Cancer
Other:	Other: