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	**□Yes □No**	**If yes, date ___/___/___**	**Results:**	**□Normal**	**□Abnormal**
Dexa Scan	**□Yes □No**	**If yes, date ___/___/___**	**Results:**	**□Normal**	**□Abnormal**
Mammogram	**□Yes □No**	**If yes, date ___/___/___**	**Results:**	**□Normal**	**□Abnormal**

Pap Smear History:

Pap smear	**□Yes □No**	**If yes, date ___/___/___**	**Results:**	**□Normal**	**□Abnormal**
LEEP	**□Yes □No**	**If yes, date ___/___/___**	**Results:**	**□Normal**	**□Abnormal**
Colposcopy	**□Yes □No**	**If yes, date ___/___/___**	**Results:**	**□Normal**	**□Abnormal**
History of HPV?	**□Yes □No**	**If yes, date ___/___/___**			
Received HPV vaccine?	**□Yes □No**	**If yes, date ___/___/___**	**□Inj.1**	**□Inj.2**	**□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 ☐A ☐B ☐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:	**1st day (date) of last period:**
Frequency of period:	**Describe Period: ☐Light ☐Normal ☐Heavy**
Length of period:	**Current Contraceptive Method:**
Do you have concerns regarding your period? describe:	**Are you in menopause? ☐Yes ☐No** **Date of last period:** **Are you on hormone replacement therapy? ☐Yes ☐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.