PHYSICIANS TO Women INC.

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PATIENT MEDICAL HISTORY

To help us meet all your healthcare needs, please fill out this form completely. This is a confidential record of your medical history and will be kept in this office.

Patient Name _____ Birthdate _____/_____/_____ Age_____

Today's date: _____/_____/_____ Date of last physical exam?_____/_____/_____

1. PAST MEDICAL HISTORY — Have you ever had the following:

☐ last Pap smear	_____	☐ Irritable Bowel Disease	_____	☐ Kidney Problems	_____
☐ last Colonoscopy	_____	☐ Hepatitis	_____	☐ Stroke	_____
☐ last Mammogram	_____	☐ PMS	_____	☐ Bladder Infections	_____
☐ last Bone Density	_____	☐ Stomach Ulcers	_____	☐ Radiation Therapy	_____
☐ Anemia	_____	☐ Herpes	_____	☐ Skin Cancer	_____
☐ Endometriosis	_____	☐ Arthritis	_____	☐ Genital Warts	_____
☐ Seizure	_____	☐ Hypertension	_____	☐ Depression	_____
☐ Cancers	_____	☐ Bone Fractures	_____	☐ Leg/Lung blood clots	_____
☐ Heart Disease	_____	☐ Headaches	_____	☐ STD	_____
☐ Uterine Fibroids	_____	☐ Sickle Cell Anemia	_____	☐ Asthma	_____
☐ Thyroid Disease	_____	☐ Osteoporosis	_____	☐ any other disease	_____
☐ Diabetes	_____	☐ Pneumonia	_____		
☐ Abnormal Pap	_____	☐ Transfusions	_____		

☐ Patient denies any PMH

2. PAST SURGICAL HISTORY — Have you ever had the following:

☐ Denies any surgeries

☐ Hysterectomy _____	☐ C-Section _____	☐ D&C _____
☐ Appendix _____	☐ Gallbladder _____	☐ Breast Biopsy _____
☐ Tonsil _____	☐ Knee Surgery _____	☐ Laparoscopy _____
☐ Cosmetic _____	☐ Tubal Sterilization _____	☐ Other Surgeries _____

Please list all serious illnesses and operations you have experienced and indicate year occurred

3. MEDICATIONS: Please list all medicines you are currently taking, including dosage and how often per day:

Current Medications	Dosage (mg)	How often per day?

☐ Denies any Medications

4. Please list all ALLERGIES (food, drugs, and environment)

☐ Denies any Allergies

_____

_____

_____

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PATIENT MEDICAL HISTORY (continued)

5. FAMILY HISTORY: Has any blood relative had any of the following: (leave blank if uncertain)

☐ Denies family history of ☐ Breast Cancer ☐ Colon Cancer ☐ GYN Cancer

Relationship

☐ Cancer _____
Type _____
☐ Diabetes _____
Type _____
☐ Heart Disease _____

☐ Osteoporosis _____
☐ Genetic Problem _____
☐ High Blood Pressure _____
☐ Seizure Disorder _____
☐ Stroke _____
☐ Kidney Problems _____
☐ Leg/Lung Blood _____

6. MENSTRUAL HISTORY

Age of 1st period _____ Days between period _____ Flow: ☐ Light ☐ Medium ☐ Heavy ☐ Clots
Total days on period _____ Last Period _____ Method of Birth Control _____
Menopausal: Yes/No Age Menopause #_____ Breakthrough bleeding: Yes/No Hormone Replacement Therapy: Yes/No

7. PREGNANCY:

Total pregnancy # _____ Full Term # _____ Premature# _____ Ectopic # _____ Terminated # _____
Miscarriages # _____ Multiple # _____ Living # _____

Pregnancy details:

Birthdate	Weight	Gender	Type of Delivery	Complications	Location

8. SOCIAL HISTORY

☐ Smoking (type & amount) _____
☐ If former smoker, date quit _____
☐ Alcohol (type & amount per week) _____
☐ Street drugs (type & amount per day) _____
Occupation _____
Marital Status _____