PHYSICIANS TO WOMEN, INC.

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HEALTH HISTORY   Today's Date _____

PATIENT NAME _____ Birthdate____/____/_____ AGE_____

Preferred name _____ **Preferred pharmacy** _____

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.

PRIMARY CARE PROVIDER: _____

Other Doctors involved with your care: _____

_____

I. PAST MEDICAL HISTORY—Have you ever had the following?   ❑ None

	Dates		Dates		Dates
❑ Anemia		❑ Cancer ❑ Type:		❑ Kidney Disease	
❑ Anorexia/bulimia		❑ Depression		❑ Migraines	
❑ Anxiety		❑ Diabetes		❑ Osteopenia or Osteoporosis	
❑ Arthritis		❑ Fibromyalgia		❑ Seizures	
❑ Asthma		❑ GERD - Gastroesophageal Reflux Disease		❑ Sickle Cell disease or trait	
❑ Blood Clot (DVT/PE) and/or clotting disorder		❑ Heart Disease		❑ Stroke	
❑ Blood Transfusion		❑ Hepatitis		❑ Stomach Ulcer	
❑ Breast Cancer		❑ Hypertension (High blood pressure)		❑ Thyroid Disease	
❑ Breast Disease (Fibrocystic, cysts, lump)		❑ Irritable bowel Syndrome (IBS)		❑ Anesthesia complications	
❑ Broken bones		❑ Liver disease		❑ Other	
❑ Bowel disease		❑ Lung disease			

II. HEALTH MAINTENANCE

	Dates		Dates		Dates
❑ Last Pap Smear		❑ Last Mammogram		❑ Last Colonoscopy	
❑ Last Bone Density Test		❑ Last STD screening		❑ Last Check-up	
❑ Flu Shot		❑ HPV Vaccine		❑ Tetanus Shot	

III. CURRENT MEDICATIONS   ❑ None

Name	DOSE	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. ALLERGIES TO MEDICATIONS   ❏ None

_____   Reaction_____

_____   Reaction_____

_____   Reaction_____

V. SURGICAL HISTORY   ❏ None

	Dates		Dates
❏ Appendectomy		❏ Hysterectomy 　❏ Vaginal 　❏ Abdominal 　❏ Laproscopic	
❏ Breast Surgery (Biopsy, Lumpectomy, Mastectomy) 　❏ Left 　❏ Right		❏ Joint Surgery or replacement	
❏ Cervix procedure (LEEP, Freezing, conization)		❏ Laparoscopy	
❏ Cosmetic 　❏ Type		❏ Myomectomy (removal of uterine fibroids)	
❏ C-Section		❏ Ovary removal 　❏ Left 　❏ Right	
❏ D&C		❏ Surgery for prolapse or urinary incontinence 　❏ Vaginal sling 　❏ Mesh	
❏ Endometrial Ablation (uterus procedure to control bleeding)		❏ Tonsillectomy	
❏ Hernia Repair 　❏ Inguinal/groin 　❏ Umbilical		❏ Tubal ligation (tubes tied)	
❏ Other surgery (please list):			

VI. SOCIAL HISTORY

Marital status:　❏ Never married　❏ Married　❏ Divorced　❏ Widowed　❏ Partnered

Smoking/tobacco/vapor:　❏ Never　❏ Past　❏ Current (list below)

　Type _____ Amount _____

If former smoker: Type/Amount _____ Date quit: _____ Years of use: _____

Alcoholic　❏ Never　❏ Past　❏ 1-4 month　❏ 1-3 week　❏ 4+ per week

How many alcoholic drinks do you have when you drink?　❏ 1-2　❏ 3-4　❏ 5-6　❏ 7+

Have you used drugs recreationally or for non-medical reasons?　❏ Yes　❏ No

　If yes: dates of last use?　❏ Marijuana _____　❏ Cocaine _____

　❏ Heroin _____　❏ Pain killers / opiates _____　❏ Other _____

Have you ever been verbally, emotionally, sexually, or physically assaulted, abused or threatened by your partner or anyone else?　❏ Yes　❏ No

Occupation _____

VII. GYNECOLOGIC HISTORY:

	Dates		Dates		Dates
❏ Abnormal Pap Smear		❏ Herpes		❏ Polycystic ovaries (PCOS)	
❏ Chlamydia		❏ HIV / AIDS		❏ Pelvic Infection / PID	
❏ Endometriosis		❏ HPV		❏ Syphilis	
❏ Genital Warts		❏ Infertility		❏ Uterine fibroids	
❏ Gonorrhea		❏ Ovarian cysts		❏ Trichomonas	

Age of 1st period _____

Are you sexually active?   ❏ Yes   ❏ No   Age at first intercourse _____

    Is your sexual activity with: ❏ Men   ❏ Women   ❏ Both

    Pain with intercourse   ❏ Yes   ❏ No

    Bleeding with intercourse   ❏ Yes   ❏ No

    Have you had a new sexual partner in the past year?   ❏ Yes   ❏ No

Menopausal: Age of menopause_____   Bleeding after menopause?   ❏ Yes   ❏ No

    Have you used hormone replacement therapy?   ❏ Current   ❏ Past   ❏ Never

    Type _____ Date _____ How long? _____

    ***If menopausal, please skip to section VIII (Obstetric History)

Date of last menstrual period _____ #Days between period   ❏ <25   ❏ 25-35   ❏ >35

#Days bleeding _____   Bleeding/Spotting between periods   ❏ Yes   ❏ No

Flow: ❏ Light   ❏ Moderate   ❏ Heavy   ❏ Clots

Menstrual Cramps: ❏ Never   ❏ Sometimes   ❏ Always   ❏ Mild   ❏ Moderate   ❏ Severe

    Do you use medications for cramping?_____

    Have you had to miss work/school because of cramping or other symptoms?   ❏ Yes   ❏ No

Do you use birth control?   ❏ Yes   ❏ No   *Please check all that apply:*

    ❏ Condoms   ❏ Withdrawal / "pull out"   ❏ Rhythm / natural method   ❏ Pill

    ❏ NuvaRing   ❏ Nexplanon implant   ❏ Patch   ❏ DepoProvera

    ❏ IUD   ❏ Tubes tied   ❏ Vasectomy   ❏ Other _____

VIII. OBSTETRIC HISTORY:

Total pregnancy #_____ Full Term # _____ Premature # _____ Living children # _____

Miscarriages # _____ Terminated / abortions # _____ Ectopic # _____ Multiples (twin, triplet) # _____

	Date of delivery	Weight	Gender	Type of delivery (vaginal, forceps, vacuum, C-section	Complications	Location
1						
2						
3						
4						
5						
6						

Please indicate if any of these pregnancy related conditions apply to you:

❏ Birth Defect Type:	❏ High blood pressure	❏ Preterm labor
❏ Cerciage	❏ Injury to baby at delivery	❏ Preterm rupture of membranes (water broke early)

❏ Fetal growth restriction (baby not growing normally)	❏ Placenta abnormality
	  ❏ Abrubtion
	  ❏ Previa
		❏ Shoulder dystocia (baby's shoulder got stuck and needed extra maneuvers at delivery)

❏ Fluid problems (too much or too little)	❏ Post-partum hemorrhage (excessive bleeding after delivery)	❏ Third or fourth degree tear at delivery
❏ Gestational diabetes	❏ Preterm delivery	❏ Vaginal delivery after c-section (VBAC)
❏ Other		

IX. FAMILY HISTORY (please list mother, father, siblings, grandparent, etc.)

❏ Unknown   ❏ Adopted

	None								
Alcoholism or drug use									
Birth defects									
Blood clot and/or clotting disorder									
Breast cancer									
Colon cancer									
Colon polyps									
Cystic fibrosis									
Developmental problems									
Diabetes									
Down syndrome									
Genetic problems or condition									
Heart disease or defect									
Hypertension (High blood pressure)									
Kidney problems									
Mental illness									
Osteoporosis / hip fracture									
Ovarian cancer									
Stroke									
Uterine (endometrial) cancer									
Other cancer (List:)									
Other									