CARE FOR WOMEN

MEDICAL HISTORY INFORMATION DATE_____

Name: Last_____First_____Initial_____Age:_____DOB:_____
Race: _____Height: _____Weight:_ _____Any recent weight changes: _____
Last Menstrual Period: _____Last Pap smear taken: _____PCP name: _____
Have you ever had a Mammogram? _____ If so when? _____ _Where?_____
Are you allergic to any medications? _____ If so what? _____
PHARMACY NAME:_____ADDRESS:_____PHONE:_____
List all current medications & dosage you are taking(example: birth control pills, thyroid, hormones, etc)

1. **_____4._____**
2. **_____5._____**
3. **_____6._____**

Birth Control Method: _____

OBSTETRICAL HISTORY
Total Pregnancies _____Full Term _____Premature _____Twins _____Cesarean Section _____
Abortion _____Miscarriages _____ Total living children today _____

Year of Birth	Place of Delivery	Sex	Weight	Type of Delivery	Complications	Continue
						on back
						of page
						if needed

PREVIOUS MEDICAL HISTORY
Have you been treated by a physician in the last two years? _____ When and what for? _____
_____
Please list all surgeries you have had and when:

1. **_____3. _____**
2. **_____4. _____**

GYNECOLOGICAL HISTORY

Abnormal Pap ……..Y……N
Sexually Transmitted Disease ……..Y……N
History of Hormone Replacement Therapy…….Y……N
Difficulty Getting Pregnant……..Y……N
Problems w/Bowel Movements……..Y……N
Dysmenorrhea/Painful Menses……..Y……N
Endometriosis……..Y……N
PCOS/Hirsutism……Y……N
Uterine Fibroids……Y……N
Urinary Tract Problems……Y……N
Menopause……Y……N
Regular Menstrual Cycle……Y……N
Heavy Menses……Y……N
PMS……Y……N

FAMILY HISTORY
On the line after listed condition, write "O" for no history. Write "M" for mother. Write "F" for father.
High Blood Pressure _____Twins _____Diabetes _____Heart Disease _____Blood Clots _____
Cancer of: Breast _____ Ovaries _____ Cervix/Uterine_____ Colon _____

DO YOU NOW OR HAVE YOU EVER HAD?

Allergy to Local Anesthetics……..Y……..N
Bleeding Tendency……Y……..N
Blood Transfusion History……..Y……..N
Breast Disease or Surgery……Y……..N
Heart Valve Problem/Replacement……Y……..N
High Blood Pressure……Y……..N
Epilepsy or Seizures……..Y……..N
Excessive Alcohol Use……Y……..N
Sexually Transmitted Disease……Y……..N
Urinary Incontinence/Leakage……..Y……..N
Anemia……Y…..N
Chest Pain ……Y…..N
Heart Attack……Y….N
Cosmetic Surgery……Y……N
Heart Murmur……Y……N
Polio……Y……N
Hepatitis/Jaundice……Y……N
Illegal Drug Use……Y……N
Smoke/Use Tobacco…. .Y……N
Thyroid Disease ……Y……N
Cancer……Y……..N
Diabetes……Y……..N
Liver Disease……Y……..N
Heart Disease……Y……..N
Liver Disease……Y……..N
Kidney Disease……Y……..N
Lung Disease……Y……..N
Stroke……Y……..N
Ulcers……Y……..N
Rheumatic Fever……Y……..N

Why are you seeing the doctor today? _____
I certify that the above information is accurate to the best of my knowledge and hereby authorize any medical information to be released to Care For Women:

Print Name _____Signature _____
Signature of Patient (Parent or Guardian if patient is a minor) **3/2014**