

**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	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date / /	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Dexa Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date / /	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Mammogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date / /	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

**Pap Smear History:**

Pap smear	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date / /	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
LEEP	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date / /	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Colposcopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date / /	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
History of HPV?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date / /			
Received HPV vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date ___/___/___	<input type="checkbox"/> Inj.1	<input type="checkbox"/> Inj.2	<input type="checkbox"/> Inj.3



**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	Indicate Yes or 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:	1 <sup>st</sup> day (date) of last period:
Frequency of period:	Describe Period: <input type="checkbox"/> Light <input type="checkbox"/> Normal <input type="checkbox"/> Heavy
Length of period:	Current Contraceptive Method:
Do you have concerns regarding your period? describe:	Are you in menopause? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last period: Are you on hormone replacement therapy? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

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**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.

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Signature

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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.