Women's Health Center, PC

Patient History Form

First Name ________ Middle Name ________ Maiden Name ________ Married Name ________

Age ________ Date of birth ________ Place of birth ________ Height ________

Have you ever been hospitalized or had any operations? ❑ YES ❑ NO If yes, fill in below.

Date	Hospital	Operations/reason for hospitalization	Doctor

Have you ever been pregnant? ❑ YES ❑ NO How many times ________

Living Children ________ # Miscarriages ________ # Terminations ________ Fill in below for each pregnancy:

Date (Mo/Yr)	# of weeks Pregnant	Length of Labor (hrs)	Sex (M/F)	Weight lbs/oz	Type of Delivery	Problems or Complications	Doctor(s)

Allergies to medications? ❑ YES ❑ NO If yes, what ________

Are you on any prescription medications regularly? ❑ YES ❑ NO If yes, fill in below

Do you take any over-the-counter, vitamin or herbal supplements daily? ❑ YES ❑ NO If yes, fill in below.

Name	Dose	Frequency	Name	Dose	Frequency

Any health problems? ❑ YES ❑ NO If yes, what ________

Do you smoke? ❑ YES ❑ NO How many cigarettes per day? ________

Do you drink? ❑ YES ❑ NO How much? ________

Do you use drugs? ❑ YES ❑ NO Type? ________ How often? ________

Family History

Please check the appropriate box if there is any history and indicate which family member:

❑ High Blood pressure ________
❑ Heart Disease ________
❑ Diabetes ________
❑ Tuberculosis ________
❑ Ovarian cancer ________
❑ Uterine cancer ________
❑ Breast cancer ________
❑ Colon Cancer ________