WOMEN'S HEALTH CARE OF NEW ENGLAND

MEDICAL HISTORY *Patient ID#* ___________________ ***Date:*** / /

Name ______________________________ Birth Date __________________ Age ______

Reason for visit/concerns you want to discuss? ______________________________

____

Allergies to Medications, X-Ray Dyes, or Other Substances .... ❒ No ❒ Yes

(If yes, please list name of medicine and type of reaction): ______________________________

____

PAST MEDICAL HISTORY - *Please check the box or boxes of the following problems*

- ❒ Alcohol Problems
- ❒ Anemia
- ❒ Arthritis: ❒ Osteo / ❒ Rheumatoid
- ❒ Asthma
- ❒ Blood Disorders: Type ________________________
- ❒ Cancer: Type: ______________________________
- ❒ h/o Chicken Pox or Shingles
- ❒ Chron's Ds
- ❒ Colon or Bowel Disease
- ❒ Depression / ❒ Anxiety
- ❒ Diabetes: ❒ Insulin / ❒ Non-Insulin
- ❒ Drug Problems
- ❒ GERD
- ❒ Heart Disease
- ❒ Hepatitis Cirrhosis or Jaundice
- ❒ High Blood Pressure
- ❒ HIV or AIDS
- ❒ Hypercholesterolemia
- ❒ IBS
- ❒ Kidney Disease or Kidney Stones
- ❒ Mitral Valve Prolapse or Heart Murmur
- ❒ Osteoporosis / ❒ Osteopenia
- ❒ Seizure Disorder/Epilepsy
- ❒ Skin Disease: Type ___________________________
- ❒ TB/Emphysema/Lung Disease
- ❒ Thyroid Disease: ❒ Hypo / ❒ Hyper
- ❒ Ulcerative Colitis
- ❒ Ulcers
- ❒ Other ______________________________

____

MEDICATIONS

(Prescriptions, Over-the-Counter, Vitamins, Herbs)

Drug Name__________________________________

Dose ______________ Frequency ______________

Drug Name__________________________________

Dose ______________ Frequency ______________

Drug Name__________________________________

Dose ______________ Frequency ______________

Drug Name__________________________________

Dose ______________ Frequency ______________

Drug Name__________________________________

Dose ______________ Frequency ______________

SURGICAL HISTORY AND HOSPITALIZATIONS

(List all hospitalizations and operations - include dates)

- Operations & Dates __________________________
- Operations & Dates __________________________
- Operations & Dates __________________________
- Operations & Dates __________________________
- Operations & Dates __________________________
- Operations & Dates __________________________

Have you ever had a blood transfusion?....❒ No ❒ Yes

This information is for use by your physician as part of your confidential medical records.

Please continue on back

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GYNECOLOGIC AND OBSTETRIC HISTORY

Name ______________________ ID # __________

Age at onset of periods: ________ Frequency ________ Length of period: ________ Last period: ________

Age of Menopause: ________ Births: ________ ❒ Normal Delivery ❒ C/Section

Number of living children: ______________ Miscarriages: ______________ Abortions: ______________

- Prolonged or abnormal bleeding: ❒ No ❒ Yes (Please describe): ____________________
- Leakage of urine: ❒ No ❒ Yes (Please describe): ____________________
- Pelvic pain: ❒ No ❒ Yes (Please describe): ____________________
- Abnormal discharge: ❒ No ❒ Yes (Please describe): ____________________
- History of abnormal Pap smear: ❒ No ❒ Yes (Please describe): ____________________

____

- History of sexually transmitted diseases (i.e. chlamydia, warts, human papilloma virus, gonorrhea, herpes)? ❒ No ❒ Yes (Please describe): ____________________
- When was your last **pap smear**? ______________
- When was your last **mammogram**? ______________
- Are you currently sexually active? ❒ No ❒ Yes
- When was your last **bone density**? ______________
- When was your last **colonoscopy**? ______________
- Birth control method? ______________ ❒ N/A

AUB → ______ DX → ______ EMB → ______ Other Diagnostics ____________________

TX ____________________ Other Gyn info/problems ____________________

SOCIAL HISTORY

Marital Status ______________ Occupation ______________

Current Sexual Partners ________ # Lifetime Sexual Partners ________ Age of 1st Intercourse ________

Do you Smoke? ❒ No ❒ Yes If yes, how many packs per day ______________

When did you start? ____________ If you quit, when? ________

Do you drink alcohol ❒ No ❒ Yes If yes, how much per week? ______________

Do you use drugs ❒ No ❒ Yes If yes, explain: *(marijuana, cocaine, etc.)* ______________

Are you in a relationship in which you have been physically hurt by your partner? .... ❒ No ❒ Yes

Have you ever engaged in any activity which has put you at risk for AIDS? .... ❒ No ❒ Yes

Do you want to be tested for AIDS? .... ❒ No ❒ Yes

Do you want to be tested for sexually transmitted diseases? .... ❒ No ❒ Yes

Have you vomited/used laxatives as a way to control your weight? ....❒ No ❒ Yes

FAMILY HISTORY

ILLNESSES	WHICH FAMILY MEMBERS	APPROX. AGE WHEN DIAGNOSED
❒ Autoimmune Disorder		
❒ Bleeding Disorders		
CANCER ❒ Breast		
❒ Colon		
❒ Lung		
❒ Ovarian		
❒ Uterine		
❒ Other:		
❒ Diabetes		
❒ Heart Disease		
❒ High Blood Pressure		
❒ Hypercholesterolemia		
❒ Osteoporosis		
❒ Stroke		
❒ Thyroid Ds		
OTHER:		

Signature ______________________________ Date ______________