CARE FOR WOMEN: MEDICAL HISTORY INFORMATION TODAY'S DATE:_____

Name: Last_____ First_____ Initial_____ Age:_____ DOB:_____
Race:_____ Height:_____ Weight:_____ Last Menstrual Period:_____ PCP Name:_____
Last Pap smear taken: _____ Have you ever had a Mammogram? _____ If so when? _____ Where? _____
Are you allergic to any medications? _____ If so what? _____
PHARMACY NAME:_____ADDRESS:_____PHONE:_____
List current medications & dosage you are taking (EX: birth control pills, thyroid, hormones, etc.)
(CONTINUE ON BACK OF THE PAGE IF NEEDED)

1. _____3._____
2. _____4._____

Birth Control Method: _____

OBSTETRICAL HISTORY

Total Pregnancies _____ Total living children today _____
Full Term_____ Premature_____ Twins_____ Cesarean Section_____ Abortion_____ Miscarriages_____

Year of Birth	Place of Delivery	Sex	Weight	Type of Delivery	Complications

(CONTINUE ON BACK OF THE 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 medical/cosmetic surgeries you have had and when:

1. _____3. _____
2. _____4. _____

GYNECOLOGICAL HISTORY

Abnormal Pap ……Y…..N
Sexually Transmitted Disease ……Y…..N
Regular Menstrual Cycle ……Y…..N
Heavy Menses/Painful Menses/PMS ……Y…..N
Endometriosis ……Y…..N
Breast Disease or Surgery ……Y…..N
Problems with Bowel Movement ……Y…..N
Difficulty Getting Pregnant ……Y…..N
PCOS/Hirsutism ……Y…..N
Menopause ……Y…..N
History of Hormone Replacement Therapy ……Y…..N
Uterine Fibroids ……Y…..N
Urinary Tract Problems ……Y…..N
Urinary Incontinence/Leakage ……Y…..N

DO YOU HAVE OR HAVE EVER HAD?

Allergy to Local Anesthetics……Y…..N
Bleeding Tendency……Y…..N
Blood Transfusion History……Y…..N
Hepatitis/Jaundice……Y…..N
Ulcers……Y…..N
Rheumatic Fever……Y…..N
Polio……Y…..N
Cancer……Y…..N
High Blood Pressure……Y…..N
Diabetes……Y…..N
Thyroid Disease……Y….N
Liver/Kidney/Lung Disease……Y….N
Anemia……Y…..N
Epilepsy or Seizures……Y…..N
Chest Pain……Y…..N
Heart Attack/Murmur/Disease……Y…..N
Stroke……Y…..N
Alcohol Use……Y…..N
Illegal Drug Use……Y…..N
Smoke/Use Tobacco……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 _____ Diabetes _____ Heart Disease _____ Blood Clots _____ Twins _____

CONTACT INFORMATION

I wish to be contacted in the following manner with my test results by:

HOME PHONE / CELL PHONE / WORK PHONE / EMAIL (CIRCLE ONE)
CHECK ONE: _____ Leave message with detailed information. _____ Only leave message with call back details.

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)