

WOMEN'S HEALTHCARE ASSOCIATES OF REDDING

PATIENT HEALTH HISTORY

PATIENT NAME _____ DOB _____

REASON FOR VISIT _____

SURGICAL HISTORY

What surgeries have you had in the past? (Do not include pregnancies)

Type? _____ Year? _____ Hospital? _____

If you have had a hysterectomy, was the surgery a vaginal or abdominal procedure? _____

MEDICATIONS (Including hormones, vitamins, herbs, and over-the-counter medications)

Drug Name? _____ Dosage? _____ Drug Name? _____ Dosage? _____

Drug Name? _____ Dosage? _____ Drug Name? _____ Dosage? _____

Drug Name? _____ Dosage? _____ Drug Name? _____ Dosage? _____

If more room is needed, please list on the bottom of this page.

VACCINES

Type? _____ Date? _____

Type? _____ Date? _____

Type? _____ Date? _____

ALLERGIES / ADVERSE REACTIONS

Drug Name? _____ What happens? _____

Drug Name? _____ What happens? _____

Drug Name? _____ What happens? _____

NOTES:

Name _____

PERSONAL MEDICAL HISTORY

If you have a problem now, or if you have had a problem with any of the following body systems in the past, please check and explain at the bottom. If you never have, please write N/A.

- | | |
|--|----------------------------------|
| _____ Anemia | _____ Heart Conditions |
| _____ Anxiety Disorder | _____ Heart Disease |
| _____ Arthritis | _____ Hyperlipidemia |
| _____ Asthma | _____ Hypertension |
| _____ Birth Defects or Inherited Disease | _____ Infertility |
| _____ Breast Cancer | _____ Kidney or Bladder Problems |
| _____ Breast Problem | _____ Lung Disease |
| _____ Cancer | _____ Obesity |
| _____ Depression | _____ Osteoporosis |
| _____ Diabetes | _____ Ovarian Cancer |
| _____ Endometriosis | _____ Psychiatric Illness |
| _____ Fibromyalgia | _____ Thyroid Problems |
| _____ GI Problems | _____ Varicosities |
| _____ Headaches or Migraines | _____ Other? |

SOCIAL HISTORY

Do you exercise? _____ How Often? _____ How Long? _____
Do you smoke cigarettes? _____ If yes, how many cigarettes per day? _____
Have you ever smoked cigarettes? _____ If yes, how long did you smoke? _____
Do you drink alcohol? _____ If yes, how many per day? _____ per week? _____ per month? _____
Illicit Drugs (street/illegal drugs)? _____ If yes, what type? _____ How often? _____

FAMILY HISTORY (Relatives who have had any of the above illnesses listed at the top of this page)

Relationship _____	Type _____	Age of onset _____
Relationship _____	Type _____	Age of onset _____
Relationship _____	Type _____	Age of onset _____

NOTES

Name _____

GYN HISTORY

What was the first day of your last period? _____ Was it heavy / moderate / light? _____

Do you have a period every month? _____ How many days between, before starting next period? _____

How long do your periods last? _____ (i.e. days, weeks)

How old were you when you had your first period? _____ Current Birth Control Method? _____

If Post Menopausal, age at Menopause? _____ Are you taking/using Hormones? _____

When was your last Pap Smear? _____ Was it normal? _____ abnormal? _____

When was your last Mammogram? _____ Was it normal? _____ abnormal? _____

Have you ever had any of the following pelvic infections? (please circle)

Yeast Bacterial Vaginosis Trichomonas Gonorrhea Syphilis Chlamydia Herpes

PATIENT'S OTHER PROVIDERS

Name _____ Phone# _____

Name _____ Phone# _____

Name _____ Phone# _____

PATIENT HISTORY – OTHER

PAST PREGNANCIES

Date of birth	# of Fetuses	Labor Length	Birth Weight	Sex	Delivery Type (vaginal or cesarean section)
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_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

OBSTETRIC HISTORY

How many time have you been pregnant? _____

Have you ever had the following: If yes, how many?

Abortions _____ Miscarriages _____ Still Births _____ Living Children _____

Ectopic _____