WOMEN'S HEALTH GROUP INC.
Patient Health History Form

Name: _____ **DOB:** _____

Medical History: Please select by circling if you (PER) or anyone in your family (FAM) has had any of the following:

Immunizations: Tetanus/Td [ ] FLU Vaccine [ ] Hep A [ ] Hep B [ ] Shingles [ ] HPV [ ] Pneumococcal [ ]								
Anemia/Blood Disorder:	Per	Fam	**Blood Clots:**	Per	Fam	**Thyroid Problems:**	Per	Fam
Weight gain/loss	Per	Fam	**Heart Attack/Disease:**	Per	Fam	**Sickle Cell Disease:**	Per	Fam
Epilepsy/Seizures	Per	Fam	**Tuberculosis:**	Per	Fam	**High Blood Pressure:**	Per	Fam
Liver Disease	Per	Fam	**Hepatitis:**	Per	Fam	**Bladder/UTI Infections:**	Per	Fam
Stroke:	Per	Fam	**Syncope/Migraines:**	Per	Fam	**Mitral Valve Prolapse:**	Per	Fam
Eye Disease	Per	Fam	**Depression/Anxiety:**	Per	Fam	**Genetic Condition (s):**	Per	Fam
Drug/Alcohol Addiction:	Per	Fam	**Blood Transfusion**	Per	Fam	**Asthma:**	Per	Fam
Pelvic Infections:	Per	Fam	**High Cholestrol:**	Per	Fam	**Respiratory Conditions:**	Per	Fam
GI issues	Per	Fam	**Diabetes:**	Per	Fam	**Arthritis:**	Per	Fam
Pneumonia	Per	Fam	**Osteoporosis/Osteopenia**	Per	Fam	**Cystic Fibrosis**	Per	Fam
Cancer: **Type:**_____	Per	Fam	**Mental Illness:** **Type:**_____	Per	Fam	**Other: Please list Below**	Per	Fam

Other: _____

Medications: _____

Allergies: _____

Past Surgical History: Please list any/all surgeries you have had with the approximate date of the surgery:

_____

_____

Smoking: How many a day?____ How many years:_____	**Alcohol:** ___ drinks per day ___ drinks per week
Caffeine: _____ cups of coffee/tea a day	**Street drug use**: Yes [ ] No [ ]

Obstetrical History: Please list pregnancies in order, including miscarriages, premature births, stillbirths, ectopic/tubal pregnancies, and abortions.

Year	M/F	Type of Delivery	Length of Pregnancy	Problems	Name	Doctor/Facility
Check here if you have **never** been pregnant: [ ]					Check here if you have adopted children: [ ]	

Please continue to the back to complete this form

Gynecological History:

Age of first period:_____ **Periods Are**: Regular [ ] Irregular [ ] Painful [ ] Bothersome [ ] Heavy [ ]
Date of last period:_____ **Cycle Length:** Every____ days
Is it common for you to have skipped cycles? Yes [ ] No [ ] **How frequently?** _____
Menopausal Symptoms: Hot Flashes [ ] Vaginal Dryness [ ] Memory problems [ ] Night Sweats [ ]
Excessive fatigue [ ] Irregular Uterine Bleeding [ ]

Are you sexually active? Yes [ ] No [ ] **Is intercourse satisfactory?** Yes [ ] No [ ]
Current # of partners: ___ **Lifetime # of Partners**: ___

Contraceptive Method (select all that apply):

IUD [ ] *Specify:*_____	Oral Contraceptive [ ] *Specify*:_____	NuvaRing [ ]	Tubal Ligation [ ]
Implantable Device [ ]	Essure [ ]	Injection [ ] (e.g. Depo-Provera)	No current [ ] contraceptive method used
Condoms/Vaginal [ ] Diaphragm	Other:		

Have you ever had any of the follow STD's: Check all that apply

Chlamydia [ ]	HPV [ ]	HIV [ ]
Gonorrhea [ ]	Syphilis [ ]	Hepatitis B [ ]
Herpes Simplex Virus [ ]	Trichomonas [ ]	Hepatitis C [ ]

Do you have or have you ever had any of the following conditions? Check all that apply

Fibrocystic Breasts [ ]	Endometriosis [ ]
Ovarian Cysts [ ]	Uterine Fibroids [ ]

Have you ever needed or has it been medically recommended that you have any of the following procedures performed due to an abnormal pap result? Check all that apply

Colposcopy [ ]	LEEP/Laser/Conization [ ]
Cryosurgery [ ]	Hysteroscopy [ ]
Other:	

Date of last Pap smear: _____ **Result of Pap smear**: Normal [ ] Abnormal [ ]
Date of last mammogram: _____ **Date of last bone density**:_____ **Date of last colonoscopy**:_____

Do you have any of the following history or family history of:

Breast cancer: [ ] Age diagnosed:___ Relative:_____	Ovarian cancer: [ ] Age diagnosed:___ Relative:_____
Uterine cancer: [ ] Age diagnosed:___ Relative:_____	Colon cancer: [ ] Age diagnosed:___ Relative:_____
High Blood Pressure: [ ] Relative:_____	Diabetes: [ ] Relative:_____
Heart Disease including heart attack, stroke, bypass surgery: [ ]	Relative:_____

If it has been 3 years since you last completed this form or have been seen at this practice you may be asked to complete this form again.