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_____

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.

GYNECOLOGIC & OBSTETRIC HISTORY

Name _____ ID# _____

Age at onset of periods: _____ Frequency: _____ Length of period: _____ Last period: _____ Age of Menopause: _____

- 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 **bone density**? _____
- When was your last **mammogram**? _____
- When was your last **colonoscopy**? _____
- Are you currently sexually active? Place/Hospital of birth: _____
- Birth control method? _____ ❑ N/A

# of pregnancies: _____ # of full term deliveries: _____ # weeks at time of delivery: _____

Place/Hospital of birth: _____ year of birth: _____ gender: _____

# of vaginal deliveries: _____ # C-sections: _____ Complications (if any): _____

# of preterm deliveries: _____ # weeks at time of delivery: _____

Place/Hospital of birth: _____ year of birth: _____ gender: _____

# of vaginal deliveries: _____ # C-sections: _____ Complications (if any): _____

Treatments/Hospitalizations: _____

# of miscarriages: _____ # weeks at time of miscarriage: _____ # of terminations _____

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 MEMBER(S)	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: _____