WELCOME TO SEVEN HILLS WOMEN'S HEALTH CENTERS

We are asking you to complete this very comprehensive form to verify all your information so that we can convert your information to an electronic medical record.

PERSONAL DATA

Name: ______________________________ Date: ___/___/___ Birth Date: ___/___/___

Referred By: ___________________________ Last 4 Digit of SS#: _________ Age: ____

Reason for visit: ☐ Routine Physical ☐ Problem Describe Problem:

CHECK IF YOU HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST:

MAJOR ILLNESS	Yes	Date of Onset	MAJOR ILLNESS	Yes	Date of Onset
Abnormal PAP Smear:			GERD / Reflux / Indigestion		
Indicate treatment by circling type below			Glaucoma		
Cone Freezing LEEP Laser			Heart Trouble		
Abnormal Uterine Bleeding			Hepatitis / Jaundice		
Treatment: Ablation			Hepatitis C		
Treatment: Hysterectomy			High Blood Pressure		
Treatment: Medication			High Cholesterol		
Anemia / low blood count			Kidney Infections		
Anxiety			Kidney Stones		
Arthritis			Osteoporosis		
Asthma			Polycystic Ovarian Syndrome (PCOS)		
Blood Transfusions			Rheumatic Fever		
Blood Clots in Leg / Lungs			Stroke		
Bowel Trouble / IBS			Sexually Transmitted Diseases		
Breast Cancer			Chlamydia		
Colon Cancer			Gonorrhea		
Ovarian Cancer			Herpes		
Cancer **enter type:**			HIV		
Chronic Lung Disease			HPV		
DES Exposure			Thyroid Problems		
Depression			Urinary Incontinence: (see below)		
Diabetes Type I or Type II (circle one)			Stress (Leakage when cough/sneeze)		
Ectopic/Tubal pregnancy			Urgency (Frequent urination)		
Endometriosis			Uterine Fibroid(s)		
Fracture -Type:			Other **enter type:**		

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:

SURGERY	DATE	SURGERY	DATE
Cone Biopsy Cervix		Cesarean Section	
Bilateral Tubal Ligation			
Hysterectomy: Type (circle one)			
Vaginal Abdominal Laparoscopic			
Ovaries Removed (circle one)			
Both Right Left			
Diagnostic Laparoscopic			
Uterine Ablation			

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

DRUG NAME	DOSAGE	FREQUENCY	START DATE	PHYSICIAN
List the Herbal or "Natural" remedies, over the counter drugs, and vitamins you use:				

ALLERGIES

DO YOU HAVE ANY KNOWN ALLERGIES TO MEDICATIONS? ☐ **Yes** ☐ **No If Yes, please check the list of medications below.**

☐ Adhesive Tape	☐ Erythromycin	☐ Latex Gloves	☐ Phenothiazines	☐ Sulfur
☐ Barbiturates	☐ Ethiodized Oil	☐ Lidocaine	☐ Phenytoin	☐ Tetracyclines
☐ Carbamazepine	☐ Ethiadol	☐ Meperidine (Demerol)	☐ Quinolones	☐ Tuberculin Test
☐ Cephalosporins (Keflex)	☐ Glucocorticoids	☐ Morphine Sulfate	☐ Salicylates	☐ **Other**
	☐ Hydrocortisone	☐ NSAIDS (Advil, Aleve, etc…)	☐ Succinimides	
☐ Codeine	☐ Insulins		☐ Sulfa	
☐ Digitalis	☐ Iodine	☐ Penicillins	☐ Sulfonylureas	

FOOD ALLERGIES SUCH AS:	☐ EGGS	☐ MILK	☐ NUTS	☐ SHELLFISH	☐ SOY	☐ YAMS

CHECK IF YOUR BLOOD RELATIVES HAVE HAD:

MAJOR ILLNESSES	YES	RELATIONSHIP TO BLOOD RELATIVE WITH DATE OR AGE OF ONSET
Anemia/ low blood count		
Anxiety		
Autoimmune Disease		
Asthma		
Blood Clots in legs / lungs		
Clotting Disorder		
Breast Cancer		
Colon Cancer		
Ovarian Cancer		
Cancer **enter type:**		
Chronic Lung Disease		
Depression		
Diabetes		
Heart Trouble / Murmur		
High Blood Pressure		
High Cholesterol		
Osteoporosis		
Stroke		
Thyroid Disease		
Other:		

GENETIC HISTORY

Complete this section if you are of child bearing years.
Please indicate if any apply to you or your family history.

☐ Anencephalus	☐ Osteogenesis Imperfecta	☐ Spina Bifida Hydrocephalus
☐ Canavan Disease	☐ Other Specified Disorders of Matbolism	☐ Spinal Cord Anomaly, Congenital
☐ Down Syndrome	☐ Other Thalassemia	☐ Tay-Sachs Disease
☐ Fragile X Syndrome	☐ Prader-Willi Syndrone	☐ Tetralogy of Fallot
☐ Habitual Aborter	☐ Septal Closure Defect	☐ Truncus Common
☐ Hemophilia	☐ Sickle-Cell Anemia	☐ Ventricular Septal Defect
☐ Huntington's Chorea	☐ Situs Inversus	
☐ Niemann-Pick Disease	☐ Spina Bifida	☐ No Genetic History
☐ Other - Describe:		

Your Reproductive History

At what age did you start your first menstrual period?

Question	Number	Question	Number
Total # of Pregnancies		Full Term Births	
Premature		Abortions Induced	
Miscarriages		Living Children	
Ectopic Pregnancy/Tubal			

On the chart below, please fill in the answers for each pregnancy including abortions and miscarriages.

	Birth Date	Wks Gest	Labor (hrs)	Baby's Weight/Sex		Del Type: Vag, Forceps, Vacuum, C-section	Anes	Early Labor?	Wt Gain	Comments / Complications	Location
1					☐ M ☐ F						
2					☐ M ☐ F						
3					☐ M ☐ F						
4					☐ M ☐ F						
5					☐ M ☐ F						
6					☐ M ☐ F						
7					☐ M ☐ F						
8					☐ M ☐ F						

Social History: Please list your life habits

Marital Status?	☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Single ☐ Dating
Adopted/Step children in household?	☐ Yes ☐ No If Yes, how many?
Do you use a seat belt?	☐ Yes ☐ No
Do you do self breast exams?	☐ Yes ☐ No
Do you eat/drink dairy products?	☐ Yes ☐ No If Yes, how many servings per day?
Do you take calcium?	☐ Yes ☐ No If Yes, Name and Dosage?
How often do you exercise?	☐ None ☐ Less than 3 times per week ☐ More than 3 times per week
Are you sexually active?	☐ Yes ☐ No
New sexual partner < 1 year?	☐ Yes ☐ No
Number of sexual partners?	☐ Less than 5 in your lifetime ☐ More than 5 in your lifetime
Do you smoke or use tobacco?	☐ Yes ☐ No If Yes, how many packs per day? How many years?
Do you drink alcohol?	☐ Yes ☐ No If Yes, how many drinks per day? Drinks per week?
Do you use drugs?	☐ Yes ☐ No If Yes, what kind? How often?
Do you have a history of abuse?	☐ Yes ☐ No If Yes, ☐ Physical ☐ Emotional ☐ Sexual When:
Your type of occupation?	

When Was Your Last Test or Immunization?

Test	Date	Results	Immunizations	Date
Last PAP Smear			Chicken Pox Vaccine	
Bone Density - DEXA Scan			Chicken Pox Exposure	
Cholesterol			Flu Shot	
Colonoscopy / Sigmoidoscopy			HPV Vaccine	
Mammogram			Pneumococcal Vaccine	
Other:			TB Skin Test	
Other:			Tetanus	

Patient Questions / Comments:

Patient's Signature: ____ **Date:** ____________

Physician Comments: