

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

**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.

<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Latex Gloves	<input type="checkbox"/> Phenothiazines	<input type="checkbox"/> Sulfur
<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Ethiodized Oil	<input type="checkbox"/> Lidocaine	<input type="checkbox"/> Phenytoin	<input type="checkbox"/> Tetracyclines
<input type="checkbox"/> Carbamazepine	<input type="checkbox"/> Ethiadol	<input type="checkbox"/> Meperidine (Demerol)	<input type="checkbox"/> Quinolones	<input type="checkbox"/> Tuberculin Test
<input type="checkbox"/> Cephalosporins (Keflex)	<input type="checkbox"/> Glucocorticoids	<input type="checkbox"/> Morphine Sulfate	<input type="checkbox"/> Salicylates	<input type="checkbox"/> <b>Other</b>
<input type="checkbox"/> Codeine	<input type="checkbox"/> Hydrocortisone	<input type="checkbox"/> NSAIDS (Advil, Aleve, etc...)	<input type="checkbox"/> Succinimides	
<input type="checkbox"/> Digitalis	<input type="checkbox"/> Insulins	<input type="checkbox"/> Penicillins	<input type="checkbox"/> Sulfa	
	<input type="checkbox"/> Iodine		<input type="checkbox"/> Sulfonyleureas	

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 <b>enter type:</b>		
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.

<input type="checkbox"/> Anencephalus	<input type="checkbox"/> Osteogenesis Imperfecta	<input type="checkbox"/> Spina Bifida Hydrocephalus
<input type="checkbox"/> Canavan Disease	<input type="checkbox"/> Other Specified Disorders of Metabolism	<input type="checkbox"/> Spinal Cord Anomaly, Congenital
<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Other Thalassemia	<input type="checkbox"/> Tay-Sachs Disease
<input type="checkbox"/> Fragile X Syndrome	<input type="checkbox"/> Prader-Willi Syndrome	<input type="checkbox"/> Tetralogy of Fallot
<input type="checkbox"/> Habitual Aborter	<input type="checkbox"/> Septal Closure Defect	<input type="checkbox"/> Truncus Common
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Sickle-Cell Anemia	<input type="checkbox"/> Ventricular Septal Defect
<input type="checkbox"/> Huntington's Chorea	<input type="checkbox"/> Situs Inversus	
<input type="checkbox"/> Niemann-Pick Disease	<input type="checkbox"/> Spina Bifida	<input type="checkbox"/> No Genetic History
<input type="checkbox"/> 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.**

Pregnancy #	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				<input type="checkbox"/> M <input type="checkbox"/> F						
2				<input type="checkbox"/> M <input type="checkbox"/> F						
3				<input type="checkbox"/> M <input type="checkbox"/> F						
4				<input type="checkbox"/> M <input type="checkbox"/> F						
5				<input type="checkbox"/> M <input type="checkbox"/> F						
6				<input type="checkbox"/> M <input type="checkbox"/> F						
7				<input type="checkbox"/> M <input type="checkbox"/> F						
8				<input type="checkbox"/> M <input type="checkbox"/> F						

### Social History: Please list your life habits

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