



THE WOMEN'S HEALTHCARE GROUP
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NEW PATIENT MEDICAL HISTORY FORM

The following information is very important to your health. Please take the time to fully and completely fill out this important information. We are counting on you.

Patient Name _____ Age _____ Birth Date _____ Date _____
 Chief Complaint: _____

List present medications/supplements: _____

List all medication allergies: _____

Family History

		<u>Cause of Death</u>	<u>Age</u>
Your Father	Living / Deceased		
Your Mother	Living / Deceased		
# of Your Siblings	#Living _____ / #Deceased _____		

Do you have a **Family History** of:

	<u>Yes</u>	<u>No</u>	<u>If Yes, which family member (indicate paternal or maternal)?</u>
Heart Disease			
High Blood Pressure			
Diabetes			
Stroke			
Cancer			
If Yes, location: _____			
Thyroid Disease/Cancer			
Other Diseases			

Review of Your Body Systems: Do you have now or have you ever had any of the following?

	<u>NO</u>	<u>YES</u>	<u>Please Explain</u>
Anemia			
Arthritis			
Blood Transfusions			
Bowel Disorders			
Breast Disease			
Cancer			
Chicken Pox			
Diabetes			
DES Exposure			
Endometriosis			
Excessive Bleeding			
Gall Bladder			
H. Hernia/Peptic Ulcer			
Headache/Migraine			
Heart Disease			
Hypertension			
Infertility			
Jaundice/Hepatitis			
Kidney Disease			
Respiratory Disease			
Psych. Illness/Depression			
Seizure Disorder			
Skin Disease			
Thyroid Disease			
Urinary Infections			
Varicose Veins/Phlebitis			

Past Surgical History:

Date	Procedure

Illness History (Other than Surgical Procedures):

Date	Illness

Tests (Give Date Last Done):

Test	Year Performed	Not Sure	Never Done	Results
Pap Smear				
Breast Exam				
Mammogram				
Rectal Exam				
Sigmoidoscopy				
Colonoscopy				
Cholesterol				
Rubella				
Triglycerides				
Thyroid Profile				
Tetanus (DPT)				
Bone Density				
Other				

Menstrual Periods:

Age Onset _____ Problems with Breasts _____
 Date of Last Period _____ Unusual Vaginal Discharge _____
 Periods: Regular ____ Irregular ____ Difficulty with Periods: _____

Pregnancies:

of Children Born Alive _____ # of Cesarean Sections _____
 # of Premature Births _____ # of Stillborns _____
 # of Miscarriages _____ # of Abortions _____

Describe any complications: _____

Your Personal Habits: Do You?

	Yes	No	Please Explain
Do you exercise regularly (3 to 4 times per week)?			
Do you use illegal drugs?			
Do you use alcohol?			
Were you ever a heavy drinker?			
Do you smoke?			
If ever, when did you stop?			
Do you have an eating disorder? Anorexia Bulimia			
Have you ever been physically abused?			
Are you currently being physically abused?			
Do you feel safe in your home?			
Do you have sex with: men women both			
Any concerns?			

My signature indicates that the above information is true and correct to the best of my knowledge.

Signature _____
 Patient Signature

Date _____