Hancock Women's Center Patient History

PATIENT NAME: ____ **DATE:** ____________________

If you are uncomfortable answering any of the questions below, leave them blank and discuss them with your doctor, nurse practitioner, or nurse

GYNECOCOLOGIC HISTORY

AGE MENSTRUAL PERIODS BEGAN:		**HOW OFTEN PERIODS OCCUR:** ❑ Day(s) ❑ Week(s)	
HOW LONG PERIODS LAST: ❑ Day(s) ❑ Week(s)		**NUMBER OF HEAVY FLOW DAYS:**	
FIRST DAY OF LAST PERIOD: ______/______/________	**RECENT CHANGES IN PERIOD(S)?** ❑ Yes ❑ No **Explain:**	**PERFORM MONTHLY BREAST SELF-EXAMS?** ❑ Yes ❑ No	**EVER HAD SEX?** ❑ Yes ❑ No **CURRENTLY SEXUALLY ACTIVE?** ❑ Yes ❑ No **MORE THAN ONE SEXUAL PARTNER?** ❑ Yes ❑ No
CURRENT BIRTH CONTROL METHOD(S):			

PREVIOUS BIRTH CONTROL METHOD(S):	**REASON(S) DISCONTINUED:**	**YEARS USED:**
______________________	______________________	______________
______________________	______________________	______________
______________________	______________________	______________

DATE OF LAST PAP SMEAR: ______/______/________	**DATE OF LAST MAMMOGRAM:** ______/______/________

Check (✓) problems/conditions you have or have had in the past:

- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ Extreme menstrual pain
- ❑ Pelvic infection
- ❑ Vaginal infection
- ❑ Painful intercourse
- ❑ Bleeding with intercourse
- ❑ Fibroids
- ❑ Uterine abnormalities
- ❑ Infertility
- ❑ Abnormal mammogram
- ❑ Abnormal nipple discharge
- ❑ Breast lump
- ❑ Breast pain
- ❑ Hot flashes
- ❑ Abnormal pap smear
- ❑ Urinary problems (incontinence, UTI, etc.)
- ❑ Herpes Simplex Virus
- ❑ Chlamydia
- ❑ Gonorrhea
- ❑ Syphillis
- ❑ Human Papilloma Virus (HPV)
- ❑ Trichomoniasis
- ❑ Hepatitis
- ❑ HIV/AIDS

***OBSTETRIC HISTORY**

# PREGNANCIES	# ABORTIONS	# MISCARRIAGES	# LIVE BIRTHS	# LIVING CHILDREN	# PREMATURE BIRTHS (< 37 WKS)

BIRTH DATE	SEX	WEIGHT AT BIRTH	# WKS PREG	TYPE OF DELIVERY	COMPLICATIONS
____/____/______	M / F	_____lb _____ oz	______	Vaginal / C-Section	______________________
____/____/______	M / F	_____lb _____ oz	______	Vaginal / C-Section	______________________
____/____/______	M / F	_____lb _____ oz	______	Vaginal / C-Section	______________________
____/____/______	M / F	_____lb _____ oz	______	Vaginal / C-Section	______________________
____/____/______	M / F	_____lb _____ oz	______	Vaginal / C-Section	______________________

Check (✓) problems/conditions you have or have had during and following pregnancy:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ Preeclampsia/Toxemia
- ❑ Recurrent miscarriage
- ❑ "Baby Blues"/Post-partum depression
  Treatment: ______________________________
- ❑ Other: ____________________
  ____

GENERAL MEDICAL HISTORY*

Check (✓) problems/conditions you have or have had in the past:

- ❑ Alcoholism
- ❑ Anorexia
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood clot/disorder
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chicken Pox
- ❑ Depression
- ❑ Diabetes
- ❑ Drug abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Gall Bladder Disease
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gout
- ❑ Heart Disease
- ❑ Hernia
- ❑ High cholesterol
- ❑ High/low thyroid
- ❑ Hypertension
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Lung Disease
- ❑ Measles
- ❑ Migraines
- ❑ Mitral valve prolapse
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Staph infection
- ❑ Stroke
- ❑ Suicide attempt
- ❑ Tonsillitis
- ❑ Ulcers

CURRENTLY SMOKE? ❑ Yes ❑ No **EVER SMOKE?** ❑ Yes ❑ No **#YEARS:** ______ **# PACK(S)/DAY:** ______

YEAR	REASON FOR HOSPITALIZATION	HOSPITAL	CITY, STATE
________	______________________________	______________	______________
________	______________________________	______________	______________
________	______________________________	______________	______________

CURRENT MEDICATIONS & DOSAGE: ______________________________	**ALLERGIES:** ____________________
____	____________________
____	____________________

By signing below, I verify the information stated above is true and accurate to the best of my knowledge.

____ ____________________

Patient/Guardian Signature *Date*