WOMEN'S HEALTH
CENTER OF LEBANON

Patient History Form

Full Name: _____ DOB:_____

Family Doctor/PCP: _____

Address of Family Doctor/PCP:_____

I attest that the information here is true and correct to the best of my belief.

_____
Patient's Signature Date

ALLERGIES

Do you have any known medication allergies? ☐ NO ☐ YES _____

Please circle any other allergies: Contrast Dye Peanuts Latex Shellfish

Other allergies and reaction: _____

_____

PAST MEDICAL HISTORY

(If you have EVER had any of these conditions, please indicate with an X or √)

Breast Conditions

____ Abnormal Mammogram (fill in below)
date:_____ result: _____
____ Breast Cancer ☐ Left ☐ Right
____ Breast Implants
____ Fibrocystic Breasts
____ Other _____

Gyn Problems

____ Abnormal Pap Smear (fill in below)
date:_____ circle treatment: colpo/LEEP/cryo
____ Cervical Cancer (Neoplasm)
____ Dysmenorrhea (Painful Menses)
____ Endometrial Cancer (Uterine)
____ Endometriosis
____ Fibroids
____ Herpes infection (circle below)
Type 1 (cold sores) or Type 2 (genitals)
____ Human Papilloma Virus Infection (HPV)
____ Ovarian Cancer
____ Ovarian Cysts
____ Pelvic Inflammatory Disease (PID)
____ Polycystic Ovarian Syndrome (PCOS)
____ Sexually Transmitted Disease (circle below)
Syphilis, Gonorrhea, Chlamydia / date: ____
____ Vaginal Cancer (Neoplasm)
____ Vulvar Cancer (Neoplasm)
____ Other _____

Heart/Circulation Conditions (Cardiovascular)

____ Congenital Heart Disease
____ Congestive Heart Failure
____ Coronary Artery Disease
____ CVA (Stroke)
____ Hypertension (High Blood Pressure)
____ Irregular Heart Beat
____ Mitral Valve Disorders (MVP)
____ Pulmonary Embolism (Blood Clot in Lung)
____ Thrombophlebitis (Blood Clot in Extremity)

Endocrine (Glandular) Disorders

____ Diabetes – Type I (Insulin-Dependent - youth)
____ Diabetes – Type II (adult onset)
____Gestational Diabetes (only when pregnant)
____ Pituitary Gland Disorder
____ Thyroid Disease: circle one: Hypo / Hyper
____ High Cholesterol

Immune System Diseases

____ Chronic Fatigue Syndrome
____ Other _____

Gastrointestinal (GI) Problems

____ Colitis, Ulcerative
____ Crohn's Disease
____ Hepatitis A
____ Hepatitis B
____ Hepatitis C
____ Irritable Bowel Syndrome
____ Other _____

Blood (Hematologic) Disorders
____ Anemia
____ Bleeding Disorder
____ Clotting Disorder
____ Sickle Cell Trait or Disease
____ Thalassemia
____ Other _____

Musculoskeletal Disorders
____ Arthritis
____ Arthritis, Rheumatoid
____ Joint Pain
____ Fibromyalgia
____ Osteopenia
____ Osteoporosis
____ Scoliosis
____ Systemic Lupus Erythematosus
____ Other _____

Neurologic Disorders
____ Common Migraines
____ Headaches
____ Multiple Sclerosis
____ Seizure Disorder (Epilepsy)
____ TIA or Stroke
____ Other _____

Psychiatric or Emotional Conditions
____ ADHD/ADD
____ Bipolar (Manic-Depressive)
____ Major Depression
____ OCD (Obsessive-Compulsive Disorder)
____ Postpartum Depression
____ Severe Anxiety or Panic Attacks
____ Other _____

Respiratory (Lung) or ENT (Ear Nose Throat) Disorders
____ Asthma
____ COPD
____ Lung Cancer
____ Pneumonia - Recurrent
____ Sleep Apnea
____ Tuberculosis
____ Other _____

Skin Conditions
____ Acne (severe)
____ Eczema
____ Hirsutism (excess hair growth)
____ Hospital acquired infection (MRSA)
____ Psoriasis
____ Other _____

Urinary (Urological) Disorders
____ Calculus (Kidney Stones)
____ Pyelonephritis
____ Stress Incontinence
____ Urge Incontinence/Overactive Bladder
____ Urinary Tract Infections (UTI)
____ Other _____

Genetic Disorders
____ Cystic Fibrosis
____ Muscular Dystrophy
____ Other _____

Test / Visit	Date	Results
Pap smear		
HPV		
Annual exam		
Mammogram		
Colonoscopy		
DXA Bone Scan		

PAST SURGICAL HISTORY

(Please include any D&C, D&E, colposcopy, cryotherapy or colonoscopy)

Surgery	Date	Reason

MEDICATIONS / SUPPLEMENTS / VITAMINS YOU ARE CURRENTLY TAKING

Medication / Supplement / Vitamin	Dose	How Often	Start Date	Prescribed by

Primary Pharmacy Name _____ Phone # _____

Pharmacy Address _____

FAMILY MEDICAL HISTORY

If **ANY** close relative of yours - such as brothers, sisters, parents, other children, grandparent (maternal or paternal), or aunt or uncle - has EVER HAD or CURRENTLY HAS any of the problems listed below, please check yes and enter specific relationship to you.

Endometriosis ☐ Yes ☐ No Who: Be specific_____
Uterine Fibroids ☐ Yes ☐ No Who: Be specific_____
Breast Cancer ☐ Yes ☐ No Who: Be specific_____
Colon Cancer ☐ Yes ☐ No Who: Be specific_____
Heart Disease ☐ Yes ☐ No Who: Be specific_____
High Blood Pressure ☐ Yes ☐ No Who: Be specific_____
High Cholesterol ☐ Yes ☐ No Who: Be specific_____
Blood Clots ☐ Yes ☐ No Who: Be specific_____
Diabetes-Type I ☐ Yes ☐ No Who: Be specific_____
Diabetes-Type II ☐ Yes ☐ No Who: Be specific_____
Thyroid (Hyperthyroid) ☐ Yes ☐ No Who: Be specific_____
Thyroid (Hypothyroid) ☐ Yes ☐ No Who: Be specific_____
Lung Cancer ☐ Yes ☐ No Who: Be specific_____
Bipolar Disorder ☐ Yes ☐ No Who: Be specific _____
Malignant Tumors ☐ Yes ☐ No Who: Be specific_____
Ovarian Cancer ☐ Yes ☐ No Who: Be specific_____
Uterine Cancer ☐ Yes ☐ No Who: Be specific_____
Osteoporosis ☐ Yes ☐ No Who: Be specific_____
Other ☐ Yes ☐ No Who: Be specific_____

MENSTRUAL HISTORY

Age of first menstrual period _____ Cycle length (28 days or ?): _____
# of days bleeding with a period _____ Period flow: Light Medium Heavy

Date of last normal menstrual period (first day): _____
Birth control method currently using: _____

Age Menopause: _____ Status: PREMENOPAUSAL POSTMENOPAUSAL PERIMENOPAUSAL

SEXUAL HISTORY

Partner Preference? ☐ Male ☐ Female ☐ Both

How many sexual partners have you had in the past year? _____

How long have you been with your current partner? _____months/years (circle one)

Have you or your partner ever participated in oral intercourse? ☐ Yes ☐ No

Have you or your partner ever participated in anal intercourse? ☐ Yes ☐ No

PREGNANCY SUMMARY

Total Number of Pregnancies	**Full Term Births (> 37 wks)**	**Premature Births (< 37 wks)**	**Terminations**	**Miscarriage:** was surgery needed	**Ectopic Pregnancies:** Left or Right	**Number of Living Children**

New Patients Only!

Child's DOB	**Child's Name**	**# weeks at Delivery**	**Hours in Labor**	**Birth Weight**	**M or F**	**Vaginal C-Section VBAC**	**Complications**	**Physician/ Location**

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Alcohol Use: ☐ Never ☐ Current ☐ Former How Much:_____ Age started:____ Age stopped:____

Illegal Drug Use: ☐ Never ☐ Current ☐ Former How Often:_____ Age started:____ Age stopped:____

Which Drug(s): _____ When last used: _____

Tobacco Use: ☐ Never ☐ Current ☐ Former How Much:_____ Age started:____ Age stopped:____

Caffeine Use: ☐ Never ☐ Current ☐ Former How Much:_____ Age started:____ Age stopped:____

Exercise Habits: ☐ Active but no formal exercise ☐ Sedentary

☐ Minimal (Once weekly) ☐ Moderate (1-3 times weekly) ☐ Heavy (4 or more times weekly)

Type of exercise: _____

Occupation: _____ **Employer:** _____