Women's Health Associates

An Axia Women's Health Care Center

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New Patient History Form

Please fill in or check all that apply: **PLEASE PRINT**

Name: _____
DOB: _____
Allergies & Drug Reactions_____
_____
Medications & Dosages: _____
_____

When was your last: Menstrual Cycle: _____ Pap _____ Mammogram_____
Dexa Scan (bone density scan)_____Colonoscopy _____ Cholesterol _____ Other _____

Do you have menopausal symptoms, if so please list: _____
_____

GYN HISTORY:
Age of first period _____ How often are menstrual cycles _____ How long does it last _____
Cramps _____ How heavy _____ Clots _____
Have you had/have any of the following:
Endometriosis _____ PID _____ Herpes _____ STD's _____ Fibroids _____
Uterine Prolapse _____Other: _____
Vaccines: HPV _____ Hepatitis B _____ Other _____

SEXUAL HISTORY
Do you use any form of birth control? _____ What type? _____
Have you ever been exposed to an STD? Yes_____ No _____

OBSTETRICAL HISTORY:
How many times have you ever been pregnant? _____ How many full term children? _____
How many premature deliveries? _____ How many terminations or miscarriages? _____
If you have had deliveries, list date of births and types (vaginal or c/section or VBAC) _____
_____
Any complications of pregnancy? (eg: Preterm labor, diabetes, high blood pressure, bleeding, multiples) _____
_____

FAMILY HISTORY (list relationship, if grandparent list maternal or paternal)
Does anyone have/had breast cancer? _____ Ovarian cancer? _____
Uterine cancer? _____ Cervical cancer? _____ Colon cancer? _____
Any type of cancer? _____
Does anyone in your immediate family have any of the following?
High blood pressure? _____ Heart disease? _____ Strokes? _____
Blood clotting problems? _____Diabetes? _____ Genetic disorders? _____
Other? _____

PLEASE TURN OVER---------->

SOCIAL HISTORY

Do you smoke? _____ How much per day? _____ Do you drink alcohol? _____
Do you use any non prescribed drugs?_____ Have you ever been in treatment for addiction? _____
Do you use caffeine? _____ Do you exercise? _____

GENERAL MEDICAL HISTORY

Neurological Disorders?
Migraines _____ Numbness _____ Stroke _____ Multiple Sclerosis _____ Anxiety _____
Memory loss/ Alzheimer's disease _____ Mental health disorder _____ Depression _____

Respiratory Disorders?
Asthma _____ Emphysema _____ TB _____ Cystic Fibrosis _____

Breast Disorders?
Lumps/masses _____ Cysts _____ Biopsies _____ Cancer _____

Cardiac Disease?
Heart attack _____ Vascular disease _____ High blood pressure _____ Mitral Valve Prolapse _____
Palpitations/Arrhythmia _____ Blood clots _____ Congestive heart failure _____ Other _____

Gastrointestinal Disorders?
Irritable bowel _____ Celiac _____ Colitis _____ Colon cancer _____ Blood in stools _____
Rectocele _____ Other _____

Kidney/Urinary Problems?
Kidney stones _____ Kidney disease _____ Incontinence _____ Cystocele/fallen bladder _____
Urinary tract infections _____ Interstitial cystitis _____

Autoimmune/Hematologic Disorders?
Blood clotting difficulty _____ Anemia _____ Sickle cell _____ HIV _____ Lupus _____
Have you ever had a blood transfusion _____ Have you ever hemorrhaged _____

Muscle or Skeletal Disorder?
Arthritis _____ Fibromyalgia _____ Osteoporosis _____ Fractures _____ Spinal/disc disease _____
Muscle weakness/paralysis _____ Problems moving _____

SURGERIES

List dates and types of any surgeries

_____
_____
_____
_____
_____
_____