Women's Care, Inc. of Mansfield

PATIENT HISTORY FORM

Name: _____ Date of Birth: _____

Primary Care Physician/Address: _____

Medicines & Allergies (include any vitamins or over the counter medication):

Medication Dose Reason taking Prescribed By:

_____

_____

Allergies/Reaction _____

Social History:
Alcohol/Amount _____ Caffeine/Amount _____ Smoking/Amount _____ Age started_____

Past Surgical History: (please list all surgeries and approximate dates):

_____

_____

_____

Medical History: Do you now have or have you ever had:

Cardiovascular:
Blood Clot (DVT): _____ Congestive Heart Failure: _____ Heart Disease: _____
High Cholesterol: _____ Hypertension: _____ TIA/Stroke: _____ Mitral Valve Prolapse: _____

OB History:
Pregnancies: _____ Living: _____ Missed AB: _____ Delivered: _____ Vaginal or C-Section: _____
Gestational age-weeks: _____ High Blood Pressure: _____ Gestational Diabetes: _____ Other: _____

GYN History:
Last pap smear: _____ Abnormal pap/dysplasia: _____ HPV: _____ Chlamydia: _____ Gonorrhea:_____
Herpes/Type: _____ PID: _____ Premature Menopause: _____ Polycystic Ovaries: _____
Post Menopausal Bleeding: _____ Endometriosis:_____ Fibroid Tumors:_____ Age period started: _____
Hormone Replacement Therapy: _____ Hysterectomy/Type:_____ Contraception: _____

Breast History:
Last Mammogram: _____ Fibrocystic Breast: _____ Breast Lump: _____ Other: _____

Cancer History:
Breast Cancer: _____ Uterine Cancer: _____ Cervical Cancer: _____ Other: _____

Digestive History:
Crohn's Disease: _____ Peptic Ulcer: _____ Irritable Bowel Syndrome: _____ Other: _____

Endocrine/Metabolic History:
Anorexia: _____ Hypothyroid: _____ Obesity: _____ Grave's Disease: _____ Chronic Fatigue Syndrome: _____
Diabetes (Type 1 or 2): _____ Other: _____

Musculoskeletal History:
Arthritis: _____ Fibromyalgia: _____ Osteoporosis: _____ Osteopenia: _____ Other: _____

Neurologic History:
Epilepsy: _____ Migraines: _____ Other: _____

Psychiatric History:
Anxiety Disorder: _____ Depression: _____ Bipolar Disorder: _____ Panic Disorder: _____
Obsessive Compulsive Disorder: _____ Other: _____

Blood Hematologic History:
Anemia: _____ Clotting Disorder: _____ Sickle Cell Trait: _____ Other: _____

Urology History:
Kidney Stones: _____ Renal Failure: _____ Other: _____

Infection History:
Hepatitis/Type: _____ HIV: _____ Other: _____

Family Medical History: Please indicate below significant medical problems of family members. Please Indicate which family member after checking the appropriate box: □ No Family History □ Adopted

Yes	No		Yes	No	
□	□	Breast Cancer _____	□	□	Ovarian Cancer _____
□	□	Colon Cancer _____	□	□	Diabetes _____
□	□	Other Cancer _____	□	□	Endometrial Cancer_____
□	□	Heart Disease _____	□	□	Amenorrhea _____

Other (not mentioned):
_____
_____
_____
_____

Patient Signature: _____ Date: _____

Parent guardian Signature: _____ Date: _____
(If patient is under age 18)