WOMEN'S HEALTH
and Menopause Center

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date: Date of Last Physical Exam:

Last Name: First Name: Middle:

Personal Past History - Major Illnesses

Asthma	Y	N	Cancer	Y	N	Ulcers	Y	N
Pneumonia	Y	N	Lung Disease	Y	N	Kidney Inf/Stones	Y	N
Tuberculosis	Y	N	Diabetes	Y	N	Depression/Anxiety	Y	N
Anemia	Y	N	Bowel Trouble	Y	N	Seizures/Epilepsy	Y	N
Glaucoma	Y	N	Venereal Disease	Y	N	Arthritis/Joint Pain	Y	N
Heart Murmur	Y	N	Fracture	Y	N	High Blood Pressure	Y	N
Stroke	Y	N	Rheumatic Fever	Y	N	Hepatitis/Jaundice	Y	N
Thyroid Disease	Y	N						

Last PAP:
Results:
Normal
Other

Last Mammogram:
Results:
Normal
Other

Operations/Hospitalizations

Reason	Date	Reason	Date

Injuries/Illnesses

Type	Date	Type	Date

OB/GYN History

	Number		Number
Births		Abortions	
Miscarriages		Living Children	

Current Medications

Drug Name	Dosage	Drug Name	Dosage

Family History

Illness	Yes	Relative	Illness	Yes	Relative
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		

Social History

HABITS

Smoking	Yes	No	Packs per day	Years
Alcohol	Yes	No	Drinks per day	Drinks per week
Drug Use	Yes	No	MEDICATION ALLERGIES:	
Seat Belt Use	Yes	No		
Regular Exercise	Yes	No		

Completed by: Patient Office Nurse Physician

Signature of Patient:

Date reviewed by physician with patient:

Physician Signature:

Subsequent Review of History

Date Reviewed: Physician Signature:

Date Reviewed: Physician Signature:

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Review of Systems - Do you now or have you had any problems related to the following systems? Circle or check Yes or No.

Constitutional Symptoms		
Fever	Y	N
Chills	Y	N
Headache	Y	N
Other		
Eyes		
Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other		
Allergic/Immunologic		
Hay Fever	Y	N
Drug allergies	Y	N
Other		
Neurological		
Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other		
Endocrine		
Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other		
Gastrointestinal		
Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other		
Cardiovascular		
Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other		

Integumentary		
Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other		
Musculoskeletal		
Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other		
Ear/Nose/Throat/Mouth		
Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other		
Genitourinary		
Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other		
Respiratory		
Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other		
Hematologic/Lymphatic		
Swollen glands	Y	N
Blood clotting problems	Y	N
Other		
Psychologic		
Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you ever considered suicide?	Y	N
Other		

Physician use only: (Comments/Notes)

#Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician: Date: