

**PERSONAL HEALTH HISTORY**

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

WOMEN'S WELLNESS CENTER

Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

CENTER FOR MATERNAL-FETAL CARE

**ALLERGIES**  I HAVE NO KNOWN MEDICATION ALLERGIES

Latex Allergy?  No  Yes

Medication Allergies: \_\_\_\_\_

Food / Environmental: \_\_\_\_\_

**MEDICAL HISTORY** – Check if **YOU** have ever had any of the following

I HAVE NOT HAD ANY MEDICAL PROBLEMS

Diabetes  Asthma  Blood Clots

Low Thyroid  Seizure Disorder  Chicken Pox

High Blood Pressure  Anxiety  Depression

Hepatitis  Autoimmune Disorder

Previous Blood Transfusion: Year \_\_\_\_\_

Sexually Transmitted Infection - Type: \_\_\_\_\_

Abnormal Pap in the past?  No  Yes – Year: \_\_\_\_\_

List treatment, if any: \_\_\_\_\_

Other medical problems: \_\_\_\_\_

**GYNECOLOGICAL INFORMATION:**

Age at first menstrual period: \_\_\_\_\_

Are you post-menopausal?  No  Yes

When was your Last Menstrual Period? \_\_\_\_/\_\_\_\_/\_\_\_\_

What is your birth control?  None  Condoms  Pills  Patch

NuvaRing  IUD \_\_\_\_\_ (type)

Other: \_\_\_\_\_

Have you had a tubal sterilization?  No  Yes

Has your husband/partner had a vasectomy?  No  Yes

**SURGICAL HISTORY**  I HAVE NEVER HAD SURGERY

Hysterectomy Year \_\_\_\_ Abdominal or Vaginal? (Circle one)

Were ovaries removed? Yes No (Circle one)

Appendectomy Year \_\_\_\_  Gall Bladder Year \_\_\_\_

D&C Year \_\_\_\_  Cerclage Year \_\_\_\_

Cesarean section Year \_\_\_\_ (1) Year \_\_\_\_ (2) Year \_\_\_\_ (3)

Tubal sterilization Year \_\_\_\_

Bariatric Surgery Year \_\_\_\_ Type \_\_\_\_\_

Breast Surgery Year \_\_\_\_ Type \_\_\_\_\_

Other Surgeries: Year \_\_\_\_ Type \_\_\_\_\_

Year \_\_\_\_ Type \_\_\_\_\_

(ADDITIONAL ROOM ON BACK)

**OBSTETRIC HISTORY**  I HAVE NEVER BEEN PREGNANT

Number of pregnancies: \_\_\_\_\_

Number of pre-term births: \_\_\_\_ Number of full-term births: \_\_\_\_

Number of vaginal deliveries: \_\_\_\_; Cesarean sections: \_\_\_\_

Number of miscarriages: \_\_\_\_; abortions: \_\_\_\_

Number of ectopic (tubal) pregnancies: \_\_\_\_

Other losses: \_\_\_\_ Number of living children \_\_\_\_

Your age when you had your first live birth: \_\_\_\_

Pregnancy complications?  No  Yes

Please describe: \_\_\_\_\_

**DETAILED OBSTETRIC HISTORY**

**\*\*If you are of child-bearing age, please fill out the Detailed Pregnancy History on the back of this page.\*\*** → → → →

**IMMUNIZATIONS: Have you received a full series of the following?**

Hepatitis A  Yes – Date completed \_\_\_\_/\_\_\_\_/\_\_\_\_  No  Unsure

Hepatitis B  Yes – Date completed \_\_\_\_/\_\_\_\_/\_\_\_\_  No  Unsure

HPV Vaccine  Yes – Date completed \_\_\_\_/\_\_\_\_/\_\_\_\_  No  Unsure

**Have you received the following vaccines?**

Flu vaccine  Yes – Date received \_\_\_\_/\_\_\_\_/\_\_\_\_  No  Unsure

Tetanus/Tdap  Yes – Date received \_\_\_\_/\_\_\_\_/\_\_\_\_  No  Unsure

Pneumovax  Yes – Date received \_\_\_\_/\_\_\_\_/\_\_\_\_  No  Unsure

**Have you had a TB test?**  No  Yes Date of last test \_\_\_\_/\_\_\_\_/\_\_\_\_

Neg.  Pos. If Positive, how was it treated? \_\_\_\_\_

**FAMILY HISTORY** – Check if you have any **FAMILY MEMBERS** with the following conditions. (ADDITIONAL ROOM ON BACK)

**NO FAMILY HISTORY**  Adopted

Family Member(s)

Breast Cancer \_\_\_\_\_

Uterine Cancer \_\_\_\_\_

Ovarian Cancer \_\_\_\_\_

Colon Cancer \_\_\_\_\_

Heart Disease \_\_\_\_\_

Diabetes \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Blood Clots \_\_\_\_\_

**SOCIAL HISTORY & HEALTH HABITS**

Occupation (Homemaker counts!): \_\_\_\_\_

Do you drink caffeine?  No  Yes: \_\_\_\_\_ (type); \_\_\_\_\_ servings daily

Do you smoke?  No  Yes \_\_\_\_\_ cigarettes/day

Do you drink alcohol?  No  Yes \_\_\_\_\_ drinks / week

Do you use other substances?  No  Yes: \_\_\_\_\_ (type) Last use: \_\_\_\_\_

**MARITAL STATUS:**  M  S  D  W

History of Partner Violence?  No  Yes

Do you exercise?  No  Yes

Do you use a seatbelt?  No  Yes

Do you have cats at home?  No  Yes

**HEALTH SCREENINGS:**

Last Pap Smear:  None Year \_\_\_\_  Normal  Abnormal

Last Mammogram:  None Year \_\_\_\_  Normal  Abnormal

Last Colonoscopy:  None Year \_\_\_\_  Normal  Abnormal

Last Bone Density Test:  None Year \_\_\_\_  Normal  Abnormal

Last Diabetes Test:  None Year \_\_\_\_  Normal  Abnormal

Last Cholesterol Test:  None Year \_\_\_\_  Normal  Abnormal

**MEDICATIONS:** Please include birth control pills, over-the-counter medicines, herbals and vitamins. (ADDITIONAL ROOM ON BACK)

I AM NOT CURRENTLY TAKING ANY PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS OR SUPPLEMENTS

Medication Name	Strength	How Often	Prescribed by	Reason
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

