Northwest Women's Consultants
Medical History Form 2

DATE_____ **NAME**_____**DATE OF BIRTH**_____

Primary Care Physician_____

Which pharmacy do you want to use?

❑ **Pharmacy**_____ _____ ❑ **Mail Order Pharmacy**_____
Name Phone Name

The following information will assist in providing your care. This information is kept confidential.

Please fill out both sides of this form completely.

Your most recent	Date	Result	Your most recent	Date	Result
Mammogram			Cholesterol Check		
Colonoscopy			Bone Density Scan		

List new surgeries within the last year_____

List new drug allergies within the last year_____

List new medical problems diagnosed within the last year_____

List <u>ALL</u> prescription and over the counter medication and supplements you take regularly

Medication	Dose	Frequency (how often)	Prescribing physician (or over the counter)	Reason

INCLUDE ALL MEDICATIONS PRESCRIBED BY OUR OFFICE

FAMILY HISTORY:

Are there any changes in your family history within the last year?

Diagnosis_____ Family member_____

Please circle any significant symptoms you are currently having, or have had recently:

Weight gain
Weight loss
Frequent headaches
Breast lumps
Nipple discharge
Breast tenderness/pain
Chest pain
Fainting
Shortness of breath w/ exercise
Frequent bruising
Bleed easily
Joint pain
Diarrhea
Constipation
Blood in stools
Nausea/Vomiting
Abdominal pain
New skin lesions
Changes in moles
Increase in urinary frequency
Urinary urgency
Joint swelling
Cough
Wheezing
Leaking urine
Vaginal discharge
Heavy periods
Irregular periods
Painful periods
Bleeding between periods
Hot flashes
Night sweats
Facial hair growth
Seasonal allergies
Anxiety
Depression

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GYNECOLOGICAL HISTORY:

How many sexual partners have you had? _____

How many sexual partners in the last year? _____

Menopause: NO YES (If yes skip to social history section)

First day of last menstrual period? _____

How many days do your periods last? _____

How often do you get your period? _____

Current Method of Birth Control: _____

OBSTETRICAL HISTORY:

Have you been pregnant within the last year? _____

SOCIAL HISTORY

Marital Status: Single Engaged Married Divorced Widowed Domestic Partner

Do you currently smoke? NO (Never or Former- Quit when?_____) YES (how much per day?_____)

Do you drink alcohol? NO YES (how much and how often?_____)

Do you use illegal drugs? NO YES (how much and how often?_____)

How much exercise do you get? Sedentary 1-2 times/mo 1-2 times/wk 3-4 times/wk nearly every day daily

Do you perform monthly self breast exams? NO YES (Always or Sometimes)

Have you experienced sexual or physical abuse in the past or present? NO YES

Calcium/Vitamin D intake per day? None # Serving per day-_____ and/or supplements per day-_____mg