Northwest Women's Consultants
Medical History Form 1

DATE__________ **NAME**______________________________ **DATE OF BIRTH**______________

OCCUPATION______________________ **Primary Care Physician**______________________

WHO REFERRED YOU ______________________

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.

Have you ever had the following (circle all that apply)

Abnormal Mammo	DVT/PE	High Blood Pressure	Painful Periods
Abnormal Pap	Endometriosis	HIV/AIDS	Problem with Anesthesia
Anemia	Epilepsy	Irregular Vaginal Bleeding	STD-History of
Arthritis	Fibroids-Uterus	Irritable Bowel/Colon	Stroke
Asthma/Emphysema	Frequent Bladder Infections	Kidney Disease	Thyroid-Low (Hypothyroid)
Blood Transfusion	Genetic Disorder	Liver Disorder	Thyroid-High (Hyperthyroid)
Cancer-type	GERD	Lupus	Vaginal Infections
Clotting Disorder	Headaches/Migraines	Mitral Valve Prolapse	Other:
Depression	Heart Disease	Osteopenia	
Diabetes (Type I or II)	High Cholesterol	Osteoporosis	

Your most recent	Date	Result	Your most recent	Date	Result
Pap Smear			Colonoscopy		
HPV test			Cholesterol Check		
Mammogram			Bone Density Scan		

List all Surgeries and Procedures

Surgery/Procedure	Year Performed	Surgery/Procedure	Year Performed

List all prescription and over the counter medication and supplements you take regularly

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

List all allergies to medication and the reaction you have if you take them

Allergic to:	Reaction	Allergic to:	Reaction

FAMILY HISTORY: Are you Adopted? NO Yes-if blood relative history unknown, proceed to page 2

Has any blood relative had any of the following? Indicate "M" for maternal, "P" for paternal (i.e. if your Mother's mother, write MGM)

Problem	Family Member	Age onset	Problem	Family Member	Age Onset
Cancer-Breast			DVT/PE		
Cancer-Colon			Heart Disease		
Cancer-Ovarian			High Cholesterol		
Cancer-Uterine			Hypertension		
Diabetes, type I			Thyroid Disorder		
Diabetes, type II			Osteoporosis		

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GYNECOLOGICAL HISTORY:

Age of first menstruation?_______________

Menopause: NO YES since age________

First day of last menstrual period?________________

How many days do your periods last?______________

How often do you get your period?________________

Do you bleed or spot between periods? NO YES

Age of First Intercourse?________________

How many sexual partners have you had?__________

Have you ever been pregnant? NO YES how many?_____

How many children have you had?________________

Are they all living? NO YES

Have you ever had a miscarriage? NO YES how many?______

Have you ever had an abortion? NO YES how many?_______

Have you ever had an ectopic preg? NO YES how many?_____

Do you have any adopted children? NO YES how many?_____

How many sexual partners in the last year?_________

Current Method of Birth Control:____

Obstetric History

Date of delivery, miscarriage, abortion	# weeks at delivery	Length of labor	Sex of baby	Type of delivery? (vaginal or C-section)	Birth weight	Complications	Location/ Doctor

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 intake per day? None # Serving per day-_______________ and/or supplements per day-_____________mg

Please circle any 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

Diarrhea
Constipation
Blood in stools
Nausea/Vomiting
Abdominal pain
New skin lesions
Changes in moles
Increase in urinary frequency
Urinary urgency

Leaking urine
Vaginal discharge
Heavy periods
Irregular periods
Painful periods
Bleeding between periods
Hot flashes
Night sweats
Facial hair growth

Frequent bruising
Bleed easily
Joint Pain
Joint Swelling
Cough
Wheezing
Seasonal allergies
Anxiety
Depression