nature coast WOMEN'S CARE
Obstetrics, Gynecology & Women's Health

Patient History Form

Name _____
Date of Birth _____
Date _____

Current Contraception: □None □Tubal Ligation □IUD □Nuva Ring □Patch □Condoms
□Natural Family Planning □Depo Provera □Diaphragm □Pills- Brand _____
If post menopausal, are you on Hormone Replacement Therapy? □Yes □No **Have you ever been on HRT?** □Yes □No
Medication Allergies: □None □_____
List all prescription medications you are currently using: □None □_____

_____

List all non-prescription or supplements you are currently using: □None □_____

Do you smoke?	□Yes	□No	*How much?*	*How often?*
Do you drink alcohol?	□Yes	□No	*How much?*	*How often?*
Do you use recreational drugs?	□Yes	□No	*What and how often?*	
Do you perform month breast exams?	□Yes	□No	**What was the first day of your last menstrual period?**	
Do you have a history of STDs?	□Yes	□No	**When was your last PAP test?**	
Have you ever had an abnormal Pap?	□Yes	□No	**How often do you exercise?**	
Have you had 5 or more sexual partners?	□Yes	□No	**Was your age at first intercourse under 16?** □Yes □No	

Personal Past Medical History Please check (√) any boxes that apply to you now or in the past

Major Illness	Yes	No	Major Illness	Yes	No
Asthma	□	□	Rheumatic fever	□	□
Pneumonia	□	□	Ulcers	□	□
Chronic Lung Disease	□	□	Depression/Anxiety	□	□
Kidney Infections/Stones	□	□	Anemia/Blood Transfusions	□	□
Tuberculosis	□	□	Seizures/Convulsions/Epilepsy	□	□
Venereal disease	□	□	Bowel trouble	□	□
Heart Trouble/Murmur	□	□	Glaucoma	□	□
Diabetes	□	□	Arthritis/Joint pain	□	□
High Blood Pressure	□	□	Fracture	□	□
Stroke	□	□	Hepatitis/Yellow jaundice	□	□
Thyroid Disease	□	□	Cancer	□	□

If you have had cancer, please explain type and treatment: _____

_____

Past Pregnancies: Number of Pregnancies_____ Living Children_____ Miscarriages_____ AB_____

#	Date of Birth	GA Weeks	Length of Labor	Weight	Sex	Type of Delivery	Complications	Anesthesia	Hospital
1									
2									
3									
4									
5									

Surgical History □None

Month/Year:	Type of Surgery:
Month/Year:	Type of Surgery:
Month/Year:	Type of Surgery:
Month/Year:	Type of Surgery:
Month/Year:	Type of Surgery:

***Please do not leave any questions blank, if the box does not apply to you please write N/A.**

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Family Medical History Please list any major illnesses that have occurred in your family. If there any family history of: Please refer to the Key below the chart to specify the person with the illness, you may use the abbreviations provided.

Major Illness	Yes	Specify	No	Major Illness	Yes	Specify	No
Breast Cancer				Coronary Artery Disease			
Ovarian Cancer				High Cholesterol			
Thyroid Cancer				Osteoporosis			
Diabetes				High Blood Pressure			
Stroke				Other:			

KEY: Mother, Father, Brother, Sister, Paternal Grandmother (FM), Paternal Grandfather (FF), Maternal Grandmother (MM), Maternal Grandfather (MF).

Review of Systems Please check (√) any boxes that apply to you now or have applied in the past:

Review of Systems	Currently	Past	Review of Systems	Currently	Past
Constitutional			***Genitourinary***		
Weight loss	□	□	Blood in urine	□	□
Weight gain	□	□	Pain in urination	□	□
Fever	□	□	Strong urge to urinate	□	□
Fatigue	□	□	Frequency of urination	□	□
Headache	□	□	Incomplete emptying	□	□
Breast	□	□	Stress incontinence	□	□
Pain in breast	□	□	***Vaginal Problems***		
Discharge	□	□	Abnormal menstruation	□	□
Lump in breast	□	□	Painful intercourse	□	□
Ear/Nose/Throat/Mouth			Painful menstruation	□	□
Ringing in ears	□	□	Vaginal discharge	□	□
Sinus problems	□	□	Vaginal irritation	□	□
Sore throat	□	□	Vaginal pain	□	□
Mouth sores	□	□	Missed menstruation	□	□
Nose bleeds	□	□	***Skin***		
Cardiovascular			Rash	□	□
Painful breathing	□	□	New lesions	□	□
Chest pain	□	□	Dry skin	□	□
Difficult breathing on exertion	□	□	***Neurological***		
Swelling in legs	□	□	Dizziness	□	□
Palpitations of heart	□	□	Seizures	□	□
Respiratory			Numbness	□	□
Wheezing	□	□	Trouble walking	□	□
Spitting up blood	□	□	***Menopausal Symptoms***		
Shortness of breath	□	□	Hot flashes	□	□
Chronic cough	□	□	Night sweats	□	□
Gastrointestinal			***Musculoskeletal***		
Frequent diarrhea	□	□	Muscle weakness	□	□
Bloody stool	□	□	***Endocrine***		
Nausea/vomiting	□	□	Abnormal thirst	□	□
Constipation	□	□	***Hematologic/lymphatic***		
Psychiatric			Frequent bruises	□	□
Depression	□	□	Cuts that do not stop bleeding	□	□
Frequent crying	□	□	Enlarged lymph nodes	□	□

Patient Signature: _____

Parent/Guardian Signature: _____

Date: _____

***Please do not leave any questions blank, if the box does not apply to you please write N/A.**