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Patient Health Information

Patient Name: _____ Age: _____

Birth Date: _____ Today's Date: _____

Preferred Pharmacy (name/location): _____

Primary Care Doctor or Family Doctor: _____

Other current doctors: _____

CURRENT FEMALE HEALTH HISTORY

When did your last menstrual period start? _____

Pregnancy History

Please give us information about all past pregnancies. If you have never been pregnant write NONE. Please include all pregnancies including miscarriages, abortions, and ectopic (tubal) pregnancies.

Date Delivered	# Weeks Preg	Birth Weight	Sex	Delivery Type	Complications

PRIMARY PROBLEM

What is the main reason for today's appointment? _____
Please give any details about your problem that may be helpful. If you have had tests or treatments for this problem by another doctor, clinic, hospital, or ER please provide those details below.

FEMALE HEALTH HISTORY

If you have now or have ever had ANY of the following problems, please note by circling all that apply.

- Endometriosis
- Uterine fibroids
- Pelvic pain
- Ovarian cysts
- Abnormal pap smear
- Cervical cancer
- Breast cancer
- Uterine cancer
- Ovarian cancer
- Infertility
- Abnormal bleeding
- Heavy or Frequent periods
- Osteoporosis or osteopenia
- Any other female health problems (specify):

Do you currently use birth control (includes ANY: pill, shot, patch, ring, tubes tied, vasectomy, condoms, etc)? _____ If yes, what type? _____

What types of birth control have you used in the past? _____

When was your last pap smear? _____

- What were the results?

- Have you ever had tests or treatment for abnormal pap smear? (please provide details) _____

FEMALE HEALTH HISTORY (continued)

Have you ever had any of the following sexually transmitted infections?

- Chlamydia yes/no
- Gonorrhea yes/no
- Trichomonas yes/no
- Syphilis yes/no
- Herpes yes/no
- HPV or genital warts yes/no

Have you ever received the vaccine

Gardasil (the HPV, or cervical cancer vaccine)? yes/no

- If "yes," did you finish the series of 3 injections? yes/no

Breast mammogram

- Date last performed, or "none": _____
- Results of last mammogram: _____

Bone mineral density (BMD) test

- Date last performed, or "none": _____
- Results of last BMD test: _____

Colonoscopy test

- Date last performed, or "none": _____
- Results of last colonoscopy: _____

GENERAL HEALTH HISTORY

If you have now or have ever had ANY of the following, please note by circling all that apply.

Chicken Pox	Asthma or other lung problem	Cancer type? _____	Diabetes
Blood clots in blood vessels (pe or dvt)	Heart problems	Hepatitis type? _____	High blood Pressure
High cholesterol	HIV/AIDS	Kidney problems	Stroke
Seizures	Anemia	Acid reflux (GERD)	Blood transfusion

Please provide any details about the above, or other disease history: _____

PAST SURGERY HISTORY

List ALL surgeries you have ever had. Please include the year and any related problems with recovery or complications.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

OTHER PERSONAL HEALTH INFORMATION

Marital status

- Are you married, divorced, or single? _____

Occupation

- What is your occupation? _____
- Do you have work-related health risks?
(if yes, please describe) _____

Habits

- Indicate below if you use any of these substances.
 - Caffeine yes/no how much: _____
 - Tobacco yes/no how much: _____
 - Alcohol yes/no how much: _____
 - Drugs yes/no
 - what kind & how much: _____

Legal

- Do you have any of the following?
 - Living will yes/no
 - Power of Attorney yes/no

FAMILY HEALTH HISTORY

If any of your blood relatives have any of the following health problems please circle below and indicate how you are related to the person.

- Arthritis, Gout Relative type: _____
- Asthma Relative type: _____
- Colon cancer Relative type: _____
- Breast cancer Relative type: _____
- Ovarian cancer Relative type: _____
- Other cancer (specify) Relative type: _____
- Chemical dependency Relative type: _____
- Diabetes Relative type: _____
- Heart disease/heart attack Relative type: _____
- Stroke Relative type: _____
- High blood pressure Relative type: _____
- Kidney disease Relative type: _____
- Hepatitis Relative type: _____
- Tuberculosis Relative type: _____
- Genetic conditions Relative type: _____
- Birth defects/mental retardation Relative type: _____
- Other (specify) Relative type: _____

ALLERGIES

Please indicate if you are allergic to latex, medications, foods or other substances: _____

MEDICATIONS

List ALL medications you take. Provide medication name, strength, how many & how often you take it. _____

ADDITIONAL

Please use the space below to provide any additional information you feel would be helpful or important for your appointment today.

PATIENT INITIALS: _____ I certify the above information is correct. I will not hold Champion Women’s Health Specialists PC, my doctor, or any member(s) of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

PATIENT SIGNATURE: _____ **DATE:** _____