Siloam Springs Women's Center

Patient Medical History

Are you here for (please check one):
Wellness Visit[ ] Problem Visit[ ] Both[ ]
Pregnancy [ ]

Print Name:_____D.O.B:_____

Past Medical History:

Weight Loss	[ ]Yes [ ]No	Weight Gain	[ ]Yes [ ]No	Blood Clots	[ ]Yes [ ]No
Blood Transfusion	[ ]Yes [ ]No	Heart Disease	[ ]Yes [ ]No	Bleeding Problems	[ ]Yes [ ]No
High Blood Pressure	[ ]Yes [ ]No	Diabetes	[ ]Yes [ ]No	Lung Problems	[ ]Yes [ ]No
Headaches	[ ]Yes [ ]No	Thyroid Disorder	[ ]Yes [ ]No	Liver Disease	[ ]Yes [ ]No
Seizure Disorder	[ ]Yes [ ]No	Stomach Problems	[ ]Yes [ ]No	Cancer	[ ]Yes [ ]No
Kidney Disease	[ ]Yes [ ]No	Anxiety/Depression	[ ]Yes [ ]No	Genital Herpes	[ ]Yes [ ]No

STDs (gonorrhea, Chlamydia, syphilis, HPV, HIV) [ ]Yes [ ]No

Gynecological History:

Age at first period:_____ age at last period _____First day of last period_____
Number of days between periods:_____ How many days do your periods last?_____
Do you blood clots with your periods? [ ]Yes [ ]No How many would you rate your menstrual cramps? [ ]Mild [ ]Moderate
Date of last pap smear_____ [ ]Normal [ ]Abnormal Date of last mammogram_____ [ ]Normal [ ]Abnormal
Have you had a Hysterectomy [ ]Yes [ ]No Total or Partial When?_____

OB History: Total number of pregnancies_____ Preterm deliveries (less than 37 weeks)_____Miscarriages_____
Abortions_____ Number of living children_____

	Preg Year	Weeks Preg	M/F	Birth Wt	Type of Delivery	Complications	Hospital
1.							
2.							
3.							
4.							
5.							

Medications: (Please list all medications you regularly take, including nonprescription medications)

1._____2._____ 3._____
4._____ 5._____ 6._____

Drug Allergies/Latex Allergies/Food Allergies:

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

Hospitalizations: (Please list all operations and serious illness. Do not list pregnancy admissions)

	Year	Type of Surgery or Illness	Hospital
1.			
2.			
3.			
4.			

Family History of Illness:

[ ]Diabetes [ ]Blood clots in lungs or legs [ ]High Cholesterol [ ]Breast Cancer [ ]Ovarian Cancer [ ]Uterine Cancer
[ ]Other:_____

Social History:

Tobacco: Cigarettes/day_____ # of years_____ Alcohol: [ ]Rare [ ]Weekends [ ]Daily; Street drug use: [ ]Yes [ ]No

_____ _____ _____
Signature of patient or Legal Guardian Relationship Date