Siloam Springs Women's Center

Patient Medical History

Date _____ Legal Name _____Date of birth _____

Primary care physician or provider _____Pharmacy _____
Preferred Name _____ Preferred Pronouns: _____

Personal Medical History:*(Circle all that apply)*

Heart attack	High cholesterol	Bipolar disorder	Arthritis
Heart disease	Asthma	Diabetes	Osteoporosis
Clotting disorder	Tuberculosis	Thyroid disorder	HIV
Blood disorder	COPD	PCOS	Irritable bowel syndrome
Blood transfusion	Stroke	Uterine fibroids	Gastrointestinal disorder
DVT (blood clots)	Seizure disorder	Endometriosis	Reflux (GERD)
Pulmonary embolism	Depression	Liver disease	Autoimmune disorder
High blood pressure	Anxiety	Hepatitis	Cancer

Other mental health disorders: _____
Other medical disorders: _____
Do you wear glasses or contacts? Yes No

Past Surgical History:

Have you ever had a tubal ligation? Yes No
Have you ever had a hysterectomy? Yes No If yes, were your ovaries removed? Yes No
Have you ever had a breast biopsy? Yes No

Type of Surgery	Year	Surgeon or Facility

Use separate paper for additional surgeries.

Current Medications:*(Include vitamins, herbs, and other supplements)*

Name of medication	Dosage	How often?	Reason for medication

Use separate paper for additional medications.

Allergies:

Name	Reaction	Name	Reaction

Are you allergic to latex? Yes No

Gynecological History:

Age at first period _____First day of last menstrual period _____ Periods are: Monthly Irregular
Have you gone through menopause? Yes No Age at menopause _____
Are you currently sexually active? Yes No Sexual partners include: Male Female Both
Do you have more than one sexual partner? Yes No
Method of birth control _____ Do you use condoms? Yes No Sometimes
Date of last pap smear _____ Have you ever had an abnormal pap smear? Yes No
Have you completed the HPV vaccine series? Yes No Unsure
Have you ever had a sexually transmitted infection? *(Circle all that apply)*
Gonorrhea Chlamydia Trichomoniasis Syphilis HIV Hepatitis B Genital Warts Genital herpes

Pregnancy History:

Total number of: Pregnancies _____ Vaginal deliveries _____ Cesarean deliveries _____
Miscarriages _____ Abortions _____ Ectopic pregnancies _____

Delivery Date	Weeks pregnant	Vaginal/Cesarean	Gender	Birth weight	Complications

Social History:

Do you use tobacco products? Yes No If yes, specify type and amount _____
Do you have a history of tobacco use?Yes No
Do you drink alcohol? Yes No If yes, specify type and amount _____
Do you use marijuana or CBD products? Yes No Do you use recreational or illicit drugs? Yes No
Do you have a history of mental, physical, or sexual abuse? Yes No Prefer not to answer
Do you work outside the home?Yes NoIf so, what is your occupation? _____
Relationship status: Married Single Widowed Divorced Other: _____
I live with:*(Circle all that apply)*Spouse/Significant other/Parent(s)/Children/Other: _____

Screening:

Date of last mammogram: _____ Result: Normal Abnormal
Date of last colonoscopy: _____ Result: Normal Abnormal
Date of last bone density screening: _____ Result: Normal Abnormal

Family History:

Medical Condition	Family Member(s)	Medical Condition	Family Member(s)
Diabetes		Breast cancer	
Heart Disease		Ovarian cancer	
Stroke		Colorectal cancer	
Other		Other cancer	

Are you currently experiencing any of the following symptoms?*(Circle all that apply)*

Fever	Shortness of breath	Nipple discharge	Frequent headaches
Fatigue	Nausea	Pain with urination	Seizures
Hot flashes	Vomiting	Blood in urine	Anxiety
Weight gain	Diarrhea	Leakage of urine	Depression
Weight loss	Constipation	Urinating at night	Suicidal thoughts
Eye problems	Blood in stool	Muscle aches	
Irregular menstrual cycles	Prolonged bleeding	Painful joints	
Chest pain	Breast lump	Rash	
Cough	Breast pain	Fainting	