DELMED HEALTH
WOMEN'S HEALTH SERVICES

Patient History Form

Please Print and Complete All Information

(If None Please Write NONE)

Name: _____ DOB: _____ Social Security: _____

Reason for Today's Visit: _____

Last Pap Smear: _____ History of Abnormal Pap: ❒Yes ❒No Last Colonoscopy: _____ Last Mammogram: _____

Last Bone Density Scan: _____ Last Flu Shot: _____ Have you received the Pnuemovax? ❒Yes ❒No If yes, when? _____

Would you accept a blood transfusion / products if necessary to sustain life? ❒Yes ❒No

Gynecological History

Date of Last Menstrual Period: _____ Age at First Menstruation: _____ Age at Last Period/Menopause: _____

Cycle is usually every _____ Days and lasts for _____Days. Are you currently Sexually Active? ❒Yes ❒No

If yes, what type of Birth Control? _____ History of Sexually Transmitted Diseases: _____

Obstetrical History

How many times have you been Pregnant? _____ How many living children do you have? _____

Full Term: _____ Pre Term: _____ C-Section: _____ Vaginal: _____ Miscarriage: _____ Abortion: _____

Your Past Medical History: (Check all that apply to You)

High Blood Pressure: ❒ High Cholesterol: ❒ Diabetes: ❒ Heart Problems: ❒ Asthma: ❒ Kidney Stones: ❒ Reflux Problems: ❒

Depression/Anxiety: ❒ Thyroid Problems: ❒ Arthritis: ❒ Cancer: Breast ❒ Cervix ❒ Uterus ❒ Ovary ❒ Other ❒ _____

Do you or have you ever Smoked? ❒Yes ❒No If Yes, for how long? _____ Quit Date: _____

Do you drink Alcohol? ❒Yes ❒No If yes, how often? _____

Do you use illegal/street drugs? ❒Yes ❒No If yes, what type? _____ How often? _____

Past Hospitalizations/ Operations and in what Year: **If none please write NONE**

_____

_____

_____

List all Allergies and Reactions to Medications and Food Allergies: **If none please write NONE**

_____

_____

_____

Family Medical History: (Check all that apply and Who)

Heart Problems	_____	Asthma	_____
High Blood Pressure	_____	High Cholesterol	_____
Bowel Problems	_____	Depression	_____
Arthritis	_____	Osteoporosis	_____
Blood Clot/Stroke	_____	Diabetes	_____
Cancer: Who/What type?	_____		

Questions/Remarks:

_____

_____

_____

Patient Signature: _____ Date: _____