Women's Health Care of Southern Indiana, LLC
Patient History

Date:_________________________

Last Name ______________________________________ **First Name** _______________________________ **MI** _____

Date of Birth ______________________ **Age**_______ **Social Security Number** ________ - ______ - _________

When was your last Tetanus shot_ _________________________________

What is the reason for your visit today? ____

Primary Care Dr._______________________ **Pharmacy Name/Location** ___________________________________

HPI:(Dr. use) ____
____
____
____
____

Medical History □ None
Please list any medical problems that you have, the physician taking care of you and how they are treated.

Date	Medical Problem	Physician

Sugical History □ None
List all surgeries you have had including breast biopsies, tonsillectomy, appendectomy, tubal ligation.

Date	Operation	Diagnosis	Hospital/MD

Gynecologic History
Date of last menstrual period: _____________________________ □ Menopausal □ Hysterectomy
How many days in between menstrual cycles from one month to the next: __________ days □ Regular □ Irregular
Number of days you bleed: _______days □ Heavy □ Moderate □ Light
How old were you when you had your first period? ____

Date/place of last Pap test: _____________________Result__________________□ None
Have you ever had an abnormal Pap test? □ Yes □ No If Yes, when? ______________________

Have you ever had a sexually transmitted disease? □ Yes __________________ □ No
Are you sexually active? □ Yes □ No Do you have pain with intercourse? □ Yes □ No
Number of sexual partners Currently__________ Past _____________
Age first sexually active ________

What method(s) do you use to keep from getting pregnant? □ Abstinence □ Birth Control Pills
□ Condoms □ Depo Shot □ Diaphragm □ IUD □ Nexplanon □ Nothing □ Nuva Ring □ Patch
□ Tubal ligation □ Vasectomy

Date/Place of last: **Mammogram** __________________□ None **Dexascan** ___________________ □ None

Colonoscopy ___________________□ None

Pregnancy History: ☐ No pregnancies
Number of times pregnant ______(includes current pregnancy) Full term births _____ Premature births _____
Elective termination ______ Miscarriages _______ Ectopic pregnancies _____
Please list your pregnancy history:

Date	Length of pregnancy (in weeks)	Vaginal/C-section	Hospital/Delivering Physician	Gender/Name/Birth Weight

Medications
List all medications that you take (including vitamins and over the counter) with the dose and timing: ☐ None

Drug	Dose	Frequency	Reason for Med.	Prescribing MD

Allergies: List all adverse reactions or allergies you have to medications or **latex** and what happened. ☐ None

____

Family History: ☐ Adopted

	Date of Birth	Age at death	Health problems or cause of death
Father	___________	___________	_______________________________
Mother	___________	___________	_______________________________
Brothers	___________	___________	_______________________________
Sisters	___________	___________	_______________________________

Family history of:
☐ Deep vein thrombosis
☐ Pulmonary embolism
☐ Breast cancer
☐ Colon cancer
☐ Ovarian cancer

Social History: Occupation:_________________________________**Employer**__________________________________

Marital Status: Single ____ Married____ Other (Specify)_____________
How much alcohol do you drink/week? Currently ____________________ Past_____________________
Do you use nicotine? (Tobacco or vape) ☐ Yes ☐ No If Yes, how often? (Amount per day) Currently____________
How many yrs.___________ Interested in quitting? _____________

Systems Review
Please check any box that applies to the symptoms you are or have experienced:

Gastroenterology	Current	Past
Chronic Abdominal Pain	☐	☐
Frequent nausea/vomiting	☐	☐
Chronic constipation	☐	☐
Persistent diarrhea	☐	☐
Bloody/Black stools	☐	☐
Hemorrhoids	☐	☐

Urology	Current	Past
Kidney Infection	☐	☐
Recurrent Bladder Infections	☐	☐
Blood in urine	☐	☐
Painful urination	☐	☐
Kidney stones	☐	☐

Constitutional		
Recent weight gain/loss	☐	☐
Night sweats	☐	☐
Loss of appetite	☐	☐
Fever	☐	☐
Weakness	☐	☐
Abnormal thirst	☐	☐

Female Reproductive		
Heavy Periods	☐	☐
Frequent yeast infections	☐	☐
Vaginal itching	☐	☐
Vaginal dryness	☐	☐
Abnormal discharge	☐	☐
More than 2 periods a month	☐	☐

Physical Exam (Office Use)

Default Other

General ____
HEENT ____
Neck ____
Heart ____
Chest ____
Breast ____
Abdomen ____
Scar _________Pfann______LC______OC______LA_____OA____ MV_____
Back ____
Extremities ____
Neuro ____
Derm ____
Pelvic ____
Hemocult □ Negative □ Positive □ Not performed

Preventative Medicine

Breast exam □
Pap test □
Smoking/Diet/Exercise □
Calcium Supplementation □
Assessment/Plan

1.)

2.)

3.)

4.)

Consult	Level 2	IUD	UhCG	Temp ____________________
EP	Level 3	EM Bx	UA	Heart Rate ________________
NP	Level 4	Colpo Bx		Blood Pressure ______/_____
Annual exam				Weight ___________________
PST				Height ___________________
Rescue				
				Provider Initials ___________