Health History Form *(online not completed)* ***Carolina Elite Women's Care, PA***

Date: ____/____/____ *Patient Name:* _____ *Chart#:* _____

Are Medication Refills needed today? If so, list Medication(s):

GYN History: *Please Circle One*

1. *What was the first day of your last menstrual period? ____/____/____
2. *What method are you currently using to prevent pregnancy? _____
3. How many days do you flow? _____
4. How often are your periods? _____
5. Do you have painful periods? _____ Yes No
6. Do you have bleeding between periods? _____ Yes No
7. Are you planning pregnancy in the future? _____ Yes No
8. Do you have a history of abnormal Pap smears requiring treatment? _____ Yes No

Medical History: *Please Circle One*

1. *List any prescription medications, over the counter medications or herbals taken: _____
2. *List any **MEDICATION ALLERGIES**: _____
3. *List any **OTHER Allergies**: _____
4. *Are you being treated for any illness, condition or surgery by another physician, since your last annual exam, here? _____ Yes No
   If so, which physician and for what reason? _____
5. Who is your Primary Care Provider? _____
6. Do you do monthly breast exams? _____ Yes No
7. *Have you had a tetanus shot within the last 10 years? If yes, When: _____ Yes No
8. *Have you had the HPV vaccine? _____ Yes No
9. *Have you had the FLU vaccine? _____ Yes No
10. *Have you had your cholesterol checked within the last 5 years? If yes, When: _____ Yes No
    Cholesterol Results: _____ Done where? _____
11. *When was your last mammogram? _____ Results: Normal or Other: _____
12. Have you had a colonoscopy? If yes, when and findings? _____ Yes No
13. Have you had a bone density scan? If yes, when and findings? _____ Yes No

Social History: *Please Circle One*

1. *Have you ever smoked? _____ Yes No
2. *Do you drink alcohol? If yes, Amount: _____ Yes No
3. *Do you use any illegal drugs? _____ Yes No
4. *Do you wear seat belts? _____ Yes No
5. Do you have a concern about sexually transmitted diseases or testing _____ Yes No
6. *Are you or any other member of your family in an abusive situation? _____ Yes No

*CIRCLE if you **CURRENTLY** have any of the following symptoms or complaints:*

1. General: fatigue – fever – significant weight change: +/ – _____ lbs
2. Skin: abnormal mole – rash
3. Eyes: irritation – vision changes
4. Respiratory: shortness of breath – cough
5. Cardiovascular: chest pain – palpitations
6. Gastrointestinal: nausea – vomiting – abdominal pain – rectal bleeding
7. Genitourinary: blood in urine – abnormal bleeding – incontinence
8. Breast: change in breast skin – breast tenderness – breast lump – nipple discharge
9. Endocrine: *Menstrual:* irritability – bloating
   Menopausal: hot flashes – night sweats – impaired concentration
   Sexual: decreased libido – orgasmic dysfunction – painful intercourse
10. Musculoskeletal: muscle weakness – back pain
11. Psychological: depression – alcoholism – sleep disturbances
12. Over the last two weeks, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More than ½ the Days	Nearly Every Day
a. Little interest or pleasure in doing things?	○	○	○	○
b. Feeling down, depressed, or hopeless?	○	○	○	○

How did you hear about our practice? ☐ Established/Previous Patient ☐ Family/Friend ☐ Internet ☐ Other:_____
☐ Physician Referral – Physician's Name: _____

Obstetrical History:

- **New Patients:** Please complete this section appropriately & continue to next section.
- **Established Patients:** ☐ Check here if NO CHANGES within last year & continue to next section.
  - ❖ If there HAVE been changes to your OB history, please complete this section properly.

1. *How many pregnancies have you had? _____
2. *How many were: Full term _____, Premature _____, Miscarriages _____, Abortions _____?
3. *Please list each pregnancy. Please include any miscarriages and/or abortions.

	YEAR	PLACE	DURATION OF GESTATION	ANESTHESIA	DURATION OF LABOR	TYPE OF DELIVERY	WEIGHT	SEX OF BABY	COMPLICATIONS MATERNAL
1st									
2nd									
3rd									
4th									
5th									

Past Medical History:

- **New Patients:** Please complete this section appropriately & continue to next section.
- **Established Patients:** ☐ Check here if NO CHANGES within last year & continue to next section.
  - ❖ If there HAVE been changes to your Medical history, please complete this section properly.

1. *How old were you when you had your first period? _____
2. What is your usual weight? _____ What is your usual height? _____
3. *Have you ever had a blood transfusion? If yes, when: _____ Yes No
4. *Please list all Non-Obstetrical hospitalizations, surgeries or outpatient surgeries:

Date	Place	Reason	Doctor

5. *Have you ever had any of the following?

Blood Clots in your legs or lungs	Yes	No	Kidney or Bladder problems	Yes	No
Blood Diseases	Yes	No	Lung Disease / Asthma	Yes	No
Cancer (what type?)	Yes	No	Mental Problems or Depression	Yes	No
Chicken Pox	Yes	No	Migraines	Yes	No
Diabetes	Yes	No	Seizures	Yes	No
Heart Disease / Heart Problems	Yes	No	Sexually Transmitted Diseases	Yes	No
High Blood Pressure or Stroke	Yes	No	Thyroid Disease	Yes	No
High Cholesterol	Yes	No			

Family History:

- **New Patients:** Please complete this section appropriately & Sign below.
- **Established Patients:** ☐ Check here if NO CHANGES within last year & Sign below.
  - ❖ If there HAVE been changes to your Family history, please complete this section properly.

Please circle **Yes** to those that apply to **YOUR FAMILY**: (on both your **mother's or father's side -** such as children, parents, grandparents, sisters, brothers, aunts, uncles, nieces, nephews)

- *Cancer (What type?)_____ Yes No
- *Heart Disease or Heart problems that occurred before the age of 55_____ Yes No
- *Diabetes_____ Yes No
- *High Blood Pressure or Stroke_____ Yes No
- *Endometriosis_____ Yes No
- *Any other Major Medical problems_____ Yes No