Carolina Elite Women's Care, PA **Health History Form**

Patient Name: Date of Birth: .

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

Do you need any Prescriptions Refilled today? If so, please list here:

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. When was your last pap smear? ________________________
8. Do you have a history of abnormal pap smears?________________________ Yes No
9. Have you had the HPV vaccine? ________________________ Yes No
10. Do you have a history of ovarian cyst(s)?________________________ Yes No
11. Do you have a history of fibroids? ________________________ Yes No
12. Do you have a history of endometriosis? ________________________ Yes No
13. Are you planning pregnancy in the future?________________________ Yes No

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 in this list.

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

Family History:

- **New Patients:** Please complete this section appropriately & Sign below.
- **Established Patients:** ☐ Check here if NO CHANGES WITHIN THE LAST YEAR..
  - If there HAVE been changes to your FAMILY history, within the last year, 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)*

1. Cancer (What type?)________________________ Yes No
2. Diabetes________________________ Yes No
3. Endometriosis________________________ Yes No
4. Heart Disease or Heart problems that occurred before the age of 55________________________ Yes No
5. High Blood Pressure or Stroke________________________ Yes No
6. Any other Major Medical problems________________________ Yes No

Social History: *Please Circle One*

1. Smoking Status: Former smoker / Current smoker / Never smoker________________________________
2. Do you drink alcohol? If yes, Amount:____ Yes No
3. Do you use any illegal drugs?____ Yes No
4. Do you have a concern about sexually transmitted diseases or testing?__________________ Yes No
5. Are you or any other member of your family in an abusive situation?____________________ Yes No

Surgical 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 / Surgical history, please complete this section properly.

Please list all Non-Pregnancy hospitalizations, surgeries or outpatient surgeries:

Date	Place	Reason	Doctor

Medical History: *Please Circle One*

1. List any **ALLERGIES**:____
2. List any prescription medications, over the counter medications or herbals taken: ________________
   ____
3. Are you being treated for any illness, condition or surgery by another physician/provider, since your last annual exam, here?____ Yes No
   If so, which physician and for what reason?____
4. Who is your Primary Care Provider?____
5. When was your last mammogram?_________________ Results: Normal? or Other:________
6. Have you had a tetanus shot within the last 10 years? If yes, When:________________________ Yes No
7. Have you had the FLU vaccine this year? ____ Yes No
8. Have you had your cholesterol checked within the last 5 years? If yes, When:_________________ Yes No
   Cholesterol Results:_______________Done where?____________________________________
9. Have you had a colonoscopy? If yes, when and results? ______________________________ Yes No
10. Have you had a bone density scan? If yes, when and results? __________________________ Yes No
11. Do you currently have or ever had any of the below conditions:

- ☐ Abuse/Domestic Violence
- ☐ Anemia
- ☐ ART / IVF or FET
- ☐ Asthma
- ☐ Birth Defects or Inherited Disease
- ☐ Blood Clots in your legs or lung
- ☐ Blood Diseases
- ☐ Blood Transfusion
- ☐ Breast Cancer
- ☐ Cancer (what type?)__________
- ☐ Chicken Pox
- ☐ Depression / Postpartum Depression
- ☐ Diabetes
- ☐ Endometriosis
- ☐ Heart Disease / Heart Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ History of HIV
- ☐ History of Sickle Cell Anemia
- ☐ Kidney or Bladder problems
- ☐ Lung Disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Polycystic Ovarian Syndrome
- ☐ Seizures
- ☐ Sexually Transmitted Diseases
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Trauma / Violence
- ☐ OTHER:__________