

# Women to Women Healthcare

## Medical History Information Form

**Patient Name:** \_\_\_\_\_, Thank you for choosing W2W for your female healthcare needs. To help our office make sure your visit is more time efficient, please complete the following questions and bring this form with you at your appointment time.

\*Due to our new electronic prescribing, please provide your pharmacy name/phone number: \_\_\_\_\_

**First day of last period:** \_\_\_\_\_

**Date of last Pap smear:** \_\_\_\_\_ Normal Abnormal (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**Have you had an abnormal pap:** No Yes **When?** \_\_\_\_\_ **Results:** \_\_\_\_\_ **HPV:** Yes No

**Treatment:** \_\_\_\_\_ **Colposcopy:** Yes No **Cryo:** Yes No **LEEP:** Yes No **Date:** \_\_\_\_\_

Date

**Latex Allergy** Yes No

**Gardasil Inj. Given** Yes No

**Mammogram:** \_\_\_\_\_ **Do you smoke?** No Yes **How Much?** \_\_\_\_\_ **How Long?** \_\_\_\_\_

**Colonoscopy:** \_\_\_\_\_ **Do you drink alcohol?** No Yes **How much?** \_\_\_\_\_ **How often?** \_\_\_\_\_

**Bone Density:** \_\_\_\_\_ **Current Birth Control Method:** \_\_\_\_\_ **History of STD's?** No Yes

**Have you ever been Pregnant:** No Yes # of Pregnancies: \_\_\_\_\_ # of Miscarriages: \_\_\_\_\_ # of Abortions \_\_\_\_\_

# of Ectopic: \_\_\_\_\_ # of Vaginal: \_\_\_\_\_ # of C-Section: \_\_\_\_\_ # of Adopted Children: \_\_\_\_\_

**DRUG ALLERGIES**

**REACTION**

**DAILY MEDICATIONS (include dose)**

**MEDICAL PROBLEM LIST**

<u>DRUG ALLERGIES</u>	<u>REACTION</u>	<u>DAILY MEDICATIONS (include dose)</u>	<u>MEDICAL PROBLEM LIST</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Hospitalizations/Operations/Outpatient Procedures:**

DATE

HOSPITAL

OPERATION/DIAGNOSIS

PHYSICIAN

<u>DATE</u>	<u>HOSPITAL</u>	<u>OPERATION/DIAGNOSIS</u>	<u>PHYSICIAN</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Family History:**

**Are you adopted:**  No  Yes

**Member**

**Important Diseases:** High blood pressure, Cancer, Diabetes, Heart Disease, Osteoporosis

Please list any other illnesses.

**Cause of Death/Age**

Mother \_\_\_\_\_

Father \_\_\_\_\_

Sister(s) \_\_\_\_\_

Brother(s) \_\_\_\_\_

Maternal Grandmother \_\_\_\_\_

Maternal Grandfather \_\_\_\_\_

Maternal Aunt (s) \_\_\_\_\_

Maternal Uncle (s) \_\_\_\_\_

Paternal Grandmother \_\_\_\_\_

Paternal Grandfather \_\_\_\_\_

Paternal Aunt(s) \_\_\_\_\_

Paternal Uncle(s) \_\_\_\_\_

Daughter (s) \_\_\_\_\_

Son (s) \_\_\_\_\_

