Women's Health Connecticut
Women's Healthcare of New Milford
Member of Women's Health Connecticut

# PERSONAL MEDICAL HISTORY

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY. THE INFORMATION YOU PROVIDE HERE WILL BE PART OF YOUR MEDICAL RECORD.

NAME: _____ DOB: _____ LAST MENSES: _____

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DRUG ALLERGIES: NO_____YES _____
IF YES, LIST:
_____
_____
_____
_____
OTHER ALLERGIES:_____
_____
ARE YOU ALLERGIC TO LATEX? NO____ YES _____

MEDICATIONS/VITAMINS/ HERBS/SUPPLEMENTS
NO _____ YES_____ PLEASE LIST:
_____DOSAGE_____
_____DOSAGE_____
_____DOSAGE_____
_____DOSAGE_____
_____DOSAGE_____
_____DOSAGE_____
PREFERRED LOCAL PHARMACY_____
_____

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DO YOU SMOKE? NO____QUIT /WHEN_____ YES_____HOW MUCH_____PERDAY_____
ALCOHOL: NO _____ YES_____ # OF DRINKS _____ PER_____
CAFFEINE: NO_____ YES_____ TYPE_____AMOUNT_____ PER_____
STREET DRUGS: NO _____ YES _____ TYPE _____
EXERCISE: NO_____ YES_____ TYPE:_____FREQUENCY_____
SELF BREAST EXAM: NO_____ YES _____ YOUR AGE @ 1ST MENSTRUAL PERIOD_____
HAVE YOU EVER BEEN ABUSED, THREATENED OR HURT BY ANYONE? NO _____ YES _____
DO YOU WEAR YOUR SEATBELT? NO _____ YES _____
CURRENT FORM OF BIRTH CONTROL: _____
HOW LONG HAVE YOU USED THIS METHOD? _____

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ANYONE IN YOUR FAMILY WITH THE FOLLOWING: CANCER, HEART DISEASE, HIGH BLOOD PRESSURE, DIABETES, OSTEOPOROSIS, HIGH CHOLESTEROL, THYROID DISEASE
PLEASE LIST AGE & CAUSE OF DEATH IF APPLICABLE
ADOPTED _____
FATHER NO_____ IF YES, WHAT? _____
MOTHER NO _____ _____
BROTHERS NO_____ _____
SISTERS NO_____ _____
MATERNAL GRANDMOTHER _____
MATERNAL GRANDFATHER _____
MATERNAL AUNTS/UNCLES _____
PATERNAL GRANDMOTHER _____
PATERNAL GRANDFATHER _____
PATERNAL AUNTS/UNCLES _____
OTHER? _____

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OTHER THAN CHILDBIRTH, ANY HOSPITALIZATIONS OR SURGERIES? NO_____ YES_____ PLEASE LIST:
_____ WHEN _____
_____ WHEN _____
_____ WHEN _____
_____ WHEN _____

## PLEASE BE SURE BOTH SIDES ARE COMPLETED!

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PATIENT NAME: _____ DOB: _____

ANY PERSONAL HISTORY OF THE FOLLOWING MEDICAL PROBLEMS?:

| | | | |
|---|---|---|---|
| ASTHMA: | NO _____ YES _____ | HEART ATTACK: | NO _____ YES _____ |
| HYPERTENSION: | NO _____ YES _____ | HEART DISEASE: | NO _____ YES _____ |
| DIABETES: | NO _____ YES _____ | STROKE: | NO _____ YES _____ |
| THYROID DISEASE: | NO _____ YES _____ | CHRONIC PAIN: | NO _____ YES _____ |
| CHOLESTEROL: | NO _____ YES _____ | ANXIETY/DEPRESSION: | NO _____ YES _____ |
| ABNORMAL PAP: | NO _____ YES _____ | MIGRAINES: | NO _____ YES _____ |
| BLOOD CLOTS: | NO _____ YES _____ | | |

VASCULAR PROBLEMS: NO _____ YES _____ TYPE_____
NEUROLOGICAL PROBLEMS: NO _____ YES _____ TYPE_____
CANCER: NO_____ YES_____ TYPE _____
_____
_____
_____

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OBSTERICAL HISTORY:

HAVE YOU EVER BEEN PREGNANT? NO_____ IF NO, SKIP TO THE NEXT SECTION

YES _____ HOW MANY TIMES? _____

MISCARRIAGE: NO _____ YES _____ IF YES, HOW MANY? _____
ECTOPIC: NO _____ YES _____ IF YES, HOW MANY? _____
TERMINATIONS: NO _____ YES _____ IF YES, HOW MANY? _____
STILLBIRTHS: NO _____ YES _____ IF YES, HOW MANY? _____
LIVE BIRTHS: _____ VAGINAL _____ C-SECTION _____
IF APPLICABLE, ARE YOU PLANNING TO HAVE ANOTHER CHILD? _____

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CHECK THOSE BELOW IF YOU HAVE ANY *CURRENT* PROBLEMS WITH:

FATIGUE _____ FEVER _____ NIGHT SWEATS _____
VISION _____ HEARING _____ EAR OR NOSE DRAINAGE _____
COUGH _____ WHEEZING _____ SHORTNESS OF BREATH _____
PALPITATIONS _____ CHEST PAIN _____
ABDOMINAL PAIN _____ VOMITING _____ PELVIC PAIN _____
CONSTIPATION _____ DIARRHEA _____ BLOOD IN STOOL _____
PROBLEMS WALKING _____ BONE OR JOINT PAIN _____ BRUISE EASILY _____
RASH _____ WHERE _____
ANXIETY _____ DEPRESSION _____
PAINFUL PERIODS _____ HEAVY PERIODS _____ HOW FREQUENT _____
DO YOU FEEL YOUR PERIODS IMPACT THE QUALITY OF YOUR LIFE? _____NO _____ YES
BLOOD IN URINE _____ URINARY FREQUENCY _____ PAINFUL URINATION _____
LEAK URINE WHEN YOU COUGH, LAUGH OR SNEEZE? _____

**PLEASE BE SURE BOTH SIDES ARE COMPLETED!**