Women's Health Connecticut
Greater Hartford Women's Health Associates
Member of Women's Health Connecticut

Label Here

Name: _____

Date of Birth: ____/____/_____ Date:_____/_____/_____

Personal Medical History

Briefly state reason for today's visit: ○ Annual / Preventative health exam ○ other: _____

MEDICAL PROBLEMS: ***Have you had any of the following?***

- ○ High blood pressure
- ○ Heart attack
- ○ Angina
- ○ Irregular heart rhythm
- ○ Heart murmur
- ○ Mitral valve prolapsed
- ○ Rheumatic fever
- ○ Diabetes
- ○ Thyroid disease
- ○ Liver disease
- ○ Hepatitis
- ○ Kidney disease
- ○ Kidney stones
- ○ Kidney infection
- ○ frequent bladder infections
- ○ Gallstones
- ○ Ulcer
- ○ GERD
- ○ Diverticulitis
- ○ Iron deficiency anemia
- ○ Thalesemia
- ○ Bleeding disorder
- ○ Deep vein thrombosis
- ○ Pulmonary embolism
- ○ Asthma
- ○ Lung disease
- ○ Tuberculosis
- ○ Stroke
- ○ Memory problem
- ○ Dementia
- ○ Attention deficit disorder (ADHD)
- ○ Eating disorder
- ○ Obesity
- ○ Anxiety
- ○ Depression
- ○ Bipolar
- ○ Glaucoma
- ○ Migraine headaches
- ○ Colon cancer
- ○ Lung cancer
- ○ Skin cancer
- ○ Breast cancer
- ○ Uterine cancer
- ○ Ovarian cancer
- ○ Cervical cancer
- ○ Cervix dysplasia
- ○ HPV
- ○ Herpes
- ○ Gonorrhea
- ○ Chlamydia
- ○ HIV or AIDS
- ○ Syphilis
- ○ Endometriosis
- ○ other: _____

SURGICAL HISTORY: ***Have you had any of the following surgeries?***

	SURGERY	YEAR		SURGERY	YEAR		SURGERY	YEAR		SURGERY	YEAR
	Abdominal hysterectomy			Novasure			Heart surgery			Knee surgery	
	Vaginal hysterectomy			Thermal Balloon Ablation			Colon surgery			Hand surgery	
	Tubes & ovaries removed			Uterine artery Embolization			Breast biopsy			Foot surgery	
	Laparoscopy			Cryosurgery of cervix			Breast cyst aspiration			Carpel tunnel surgery	
	Surgery on tube(s)			Laser of cervix			Breast lumpectomy			Cataracts	
	Surgery on ovary			LEEP of cervix			Mastectomy			Lasik	
	Cesarean section			Vaginal repairs			Lump node biopsies			Tonsillectomy	
	Tubal ligation			TVT			Breast augmentation			Other:	
	D&C			Urethral suspension			Breast reduction				
	Hysteroscopy			Appendectomy			Back surgery				
	Essure			Gall bladder			Shoulder surgery				

List any medications you take regularly, including dosage:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

What supplements do you take? ○ Multivitamins ○ Iron ○ Calcium ○ vitamin D ○ Other: _____

List any known allergies: _____ Type of reaction: _____

_____ Type of reaction: _____

Are you performing Self-Breast exam? ○ YES ○ NO ○ Sometimes

Last Mammography: _____/___/_____ Facility: _____

Last PAP Test: _____/___/_____ ○ Normal ○ Abnormal

Are you sexually active: ○ YES ○ NO What form of birth control do you use? _____

Last Bone Density: _____/___/_____ Last Colonoscopy: _____/___/_____

List all pregnancies: (please include miscarriages and terminations) ○ **N / A**

Date of delivery	Sex of baby	Type of delivery	Pregnancy complications	Post Partum complications
1.				
2.				
3.				
4.				
5.				

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Personal Medical History (continued)

Family History:

Is your father living? ○ YES ○ NO If no, age & cause of death: _____

Is your mother living? ○ YES ○ NO If no, age & cause of death: _____

How many brothers do you have? _____ All living? ○ YES ○ NO If no, age & cause of death: _____

How many sisters do you have? _____ All living? ○ YES ○ NO If no, age & cause of death: _____

Do any of your blood relatives have any of the following?

	Relation		Relation		Relation		Relation
Breast cancer		Heart disease		Kidney disease		Cystic Fibrosis	
Ovarian cancer		Heart attack		Thyroid disease		Muscular Dystrophy	
Colon cancer		Stroke		Down syndrome		Mental Retardation	
Osteoporosis		DVT		Sickle Cell		Fragile X	
Diabetes		High blood pressure		Thalesemia		Tay-Sachs	
Bleeding problems		Pulmonary Embolism		Hemophilia		Huntington Chorea	

Social History:

Do you exercise? ○ Never ○ Rarely ○ Daily ○ # days per week

Do you smoke? ○ Never ○ Quit, when? ○ YES, pack(s) per day

○ Tobacco ○ Electric Cigarette ○ Other _____

Second hand smoke exposure? ○ Yes ○ No

Do you drink? ○ Never ○ Rarely ○ Daily ○ # days per week ○ beer ○ wine ○ liquor

Do you use street drugs? ○ Never ○ Rarely ○ Daily ○ # days per week

Do you drink caffeine? ○ Yes ○ No How many cups per day? 1 2 3 4 ○ Coffee ○ Tea ○ Soda

Have you been abused, threatened, or hurt by anyone? ○ YES ○ NO

Please mark with √ all that apply TODAY:

General	**Cardiovascular**	**Neurological**
○ recent weight change	○ chest pain	○ fainting / dizziness
○ increased headaches	○ palpitations	○ numbness/tingling
○ sleeping problems		
○ poor appetite	**Peripheral Vascular:**	**Emotional:**
○ fatigue	○ varicose veins	○ nervousness / anxiety
	○ phlebitis	○ depression
Neck	○ edema / swelling	
○ swollen glands		**Genitourinary:**
	Gastrointestinal:	○ painful voiding
Eyes	○ nausea	○ blood in urine
○ glasses / contacts	○ vomiting	○ frequent voiding
○ double vision	○ diarrhea	○ night voiding
	○ constipation	○ urgency
Ears	○ abdominal pain	○ incontinence/loss of urine
○ vertigo / spinning	○ change in bowels	○ heavy menses
○ ringing	○ food intolerance	○ irregular menses
○ hearing loss	○ rectal bleeding	○ absent menses
	○ hemorrhoids	
Nose / Throat	○ jaundice	**Hematologic**
○ nose bleeds		○ anemia
○ bleeding gums	**Respiratory**	○ easy bruising
	○ chronic cough	○ bleeding
Breasts	○ sputum	
○ masses / lumps	○ cough blood	**Endocrine**
○ pain	○ short of breath	○ excessive sweating
○ discharge		○ heart or cold intolerance

Pharmacy Name: _____ **Town:** _____

Patient Signature: _____ **Date:** _____

02/1/2019 updated