NAME: _____

DATE OF BIRTH: _____

REASON FOR VISIT: _____

REFERRED BY: _____

ATHENS Women's & CHILDREN'S CENTER

Patient History Form

OBSTETRIC HISTORY

	Year	*M/F*	*Weight*	*Length of Pregnancy*	*Type of Delivery*	*Problems*
# of Pregnancies ____						
# of Full-Term Deliveries ____						
# of Premature Deliveries ____						
# of Miscarriages/Ectopics ____						
# of Abortions ____						

GYNECOLOGIC HISTORY

Age of first period: _____

Last menstrual period: _____

Cycles: every ____ days Cycles are: ☐ Regular ☐ Irregular

lasting ____ days Flow is: ☐ Light ☐ Moderate ☐ Heavy ☐ Painful

Sexual preference: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

Birth control method: _____

Any history of sexually transmitted diseases? ☐ Y ☐ N

Last Pap Smear: _____ Any history of abnormal tests? ☐ Y ☐ N

Last Mammogram: _____ Any history of abnormal tests? ☐ Y ☐ N

Last Bone Scan: _____ Any history of abnormal tests? ☐ Y ☐ N

Last Colonoscopy: _____ Any history of abnormal tests? ☐ Y ☐ N

MEDICAL HISTORY

Have you ever had any of the following?

- ☐ High Blood Pressure
- ☐ Heart Disease/Attack
- ☐ Stroke
- ☐ Blood Clots
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Bleeding Problems
- ☐ Asthma
- ☐ Migraines
- ☐ Thyroid Disease
- ☐ Depression/Anxiety
- ☐ Cancer
- ☐ Other: _____

SURGICAL HISTORY

Please list all of your surgeries:

_____ date _____ _____ date _____

_____ date _____ _____ date _____

MEDICATIONS

Please list all of your current medications & vitamins:

_____ _____ _____ _____

_____ _____ _____ _____

ALLERGIES

Please list all of your allergies:

☐ None _____

_____ _____

SOCIAL HISTORY

Marital status: _____ Religion, if any: _____

Occupation: _____ Any abuse, emotional or physical? ☐ Y ☐ N

Do you exercise?	☐ Y ☐ N	Type & frequency:	_____
Do you drink caffeine?	☐ Y ☐ N	How much?	_____
Do you smoke?	☐ Y ☐ N	How much?	_____
Do you drink alcohol?	☐ Y ☐ N	How often?	_____
Do you use drugs?	☐ Y ☐ N	Which ones?	_____

FAMILY HISTORY

Has anyone in your family ever had any of the following?

- ☐ High Blood Pressure
- ☐ Heart Disease/Attack
- ☐ Breast Cancer
- ☐ Uterine Cancer
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Colon Cancer
- ☐ Ovarian Cancer
- ☐ Blood Clots
- ☐ Down Syndrome
- ☐ Cystic Fibrosis
- ☐ Tay-Sachs Disease
- ☐ Bleeding Problems
- ☐ Neural Tube Defect
- ☐ Sickle Cell Disease
- ☐ A/B-Thalessemia