



# Pali Women's HEALTH CENTER

642 Ulukahiki St. # 305  
Kailua, HI 96734

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## PATIENT HISTORY FORM

Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_

Current List of Medications: \_\_\_\_\_

List any health conditions (ex: Diabetes, high blood pressure): \_\_\_\_\_

Allergies to drugs/medications/x-ray dye/latex: \_\_\_\_\_

Last Menstrual Period: \_\_\_\_\_ Are your periods Light, Normal, or Heavy? (please circle)

How often are your periods? every 28 days/ every 20-25 days/ every 35-40 days/ irregular?(please circle)

How long do your periods last? 1-3 days / 3-5 days / 5-7 days / more than 7 days? (please circle)

Do you have cramping with your periods? No or Yes. If yes: Mild, Moderate, Severe (please circle)

Are you currently sexually active: Yes or No (please circle) Birth control method: \_\_\_\_\_

Last pap smear: \_\_\_\_\_ Do you have a history of abnormal pap smears? Yes or No

Last Mammogram: \_\_\_\_\_ Last Bone Density: \_\_\_\_\_ Last Colonoscopy: \_\_\_\_\_

### Pregnancy History:

Year	Male/Female	Weight	Vaginal/C-section	Complications
1. _____				
2. _____				
3. _____				
4. _____				

### Surgical History:

Date	Type of Surgery	Doctor	Hospital
1. _____			
2. _____			
3. _____			
4. _____			

### Family History:

Any relevant family history (ex: cancer, diabetes, hypertension)? If so, who and what kind: \_\_\_\_\_

Do you smoke cigarettes? If so how much per day: \_\_\_\_\_

Do you drink alcohol? If so how many drinks per week: \_\_\_\_\_

Any recreational drug use? Yes or No (please circle)

Do you exercise? If so how many times per week: \_\_\_\_\_