LOUISIANA WOMEN'S Healthcare

500 RUE DE LA VIE, SUITE 100 • BATON ROUGE, LOUISIANA 70817 • 225-201-2000

Pat. Name _____

Date of Birth _____

Patient I.D. _____

Physician _____

AFFIX LABEL HERE

Date _____

Reason for Today's Visit _____

HEALTH HISTORY FORM

PLEASE LIST

Allergies	Current Medications	Previous Surgery

SCREENING TESTS

Test	Date/Year	Normal	Abnormal	HAVE YOU EVER HAD THE FOLLOWING:	
Pap Smear				☐ High Blood Pressure	☐ Seizures
Mammogram				☐ Heart Disease	☐ Hcpatitis/Jaundice
Bone Scan				☐ TB	☐ Thrombophlebitis/Blood Clots
Colon Cancer				☐ Diabetes	☐ Sexually Transmitted Diseases
Cholesterol				☐ Asthma	☐ Any other serious illness/injury

Personal History:

Do you eat a well balanced diet? _____

Do you drink alcohol? _____

Have you ever been treated for alcoholism? _____

Do you have a history of drug abuse? _____

Have you ever been treated for drug abuse? _____

Do you smoke? _____

Do you exercise? _____

Do you feel rested after sleep? _____

Have you recently experienced domestic violence or feel threatened? _____

Menstrual History:

Age first period began _____

Cycle length (example 28 days) _____

Number of days of flow _____

How old were you when you had your first full term pregnancy _____

Date last period began _____

Irregular periods? _____

Bleed between periods? _____

Heavy flow/clots/cramps? _____

PREGNANCY HISTORY

Year of Delivery	Full Term / Premature / Stillborn / Miscarriage / Abortion / C-section / Vaginal Del. / VBAC	List Complications i.e. High Blood Pressure, Tubal Pregnancy, Gestational Diabetes, etc.	Sex of Child	Weight of Child
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FAMILY HISTORY

Family Member	Illnesses or Medical Conditions	Age at Death	Cause of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

WHO IN YOUR FAMILY (Living or Deceased) HAS OR HAD THE FOLLOWING:

Cancer	Inherited Diseases	Diabetes
Breast Cancer	Birth Defects	Epilepsy
Ovarian Cancer	Sickle Cell Anemia	Heart Disease
Uterine Cancer	Mental Retardation	High Blood Pressure
Other Female Cancer	Any other inherited diseases	Mental Illness
Colon Cancer		TB (Tuberculosis)

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