Women's Health Specialists of Dallas, P.A. - 8160 Walnut Hill Ln., Ste 200, Dallas, TX 75231 - (214)363-4421

Patient History

Date: _____ Referred By: _____

Patient's Name: _____ Birthdate: _____

Reason for visit: ☐ Annual Well Woman Exam ☐ Problem Visit ☐ First Prenatal Visit/Pregnant

Are there any issues to discuss with your doctor? _____

If you are here for an annual/well-woman exam and you would like to discuss any additional issues/problems you may have, your insurance company may not cover both. In most instances, well-woman visits are covered, but any additional testing/diagnosis regarding problems may not be covered and therefore cannot be addressed at this visit. Please understand that this is not a policy created by our office or your physician, but the direct effect of changes to our healthcare system.

Would you like to change your visit to be able to discuss these issues? ☐ Yes ☐ No

** If there are any questions you do not feel comfortable answering here, please feel free to discuss them with your doctor privately.*

Allergies: ☐Yes ☐ No

Medication/Substance	Reaction

Medications/Vitamins/Supplements: ☐ Yes ☐ No

Medication (include dosage)	Diagnosis	Date started	Currently taking?	Prescribing Doctor

Obstetrical History: (All past pregnancies) ☐ Yes ☐ No

#	Date of birth	Type *	(M/F)	Weight	Name	Doctor/Hospital	Complications (Pregnancy or Delivery)

* Delivery types: Vaginal (vag), Cesarean Section (c/s), Vacuum/Forceps (op), Miscarriage (sab), Termination (top) and Ectopic/Tubal Pregnancy (e)

Surgical History: ☐ Yes ☐ No

Date	Procedure	Indication	Complication	Physician/Hospital

Non - Surgical Hospitalizations: ☐ Yes ☐ No

Date	Indication/Reason	Physician/Hospital

Social History

Tobacco Use? ☐ Yes ☐ No How Much? _____ Type: _____

Alcohol Use? ☐ Yes ☐ No How Much? _____ Type: _____

Drug Use? ☐ Yes ☐ No How Much? _____ Type: _____

Caffeine Use? ☐ Yes ☐ No How Much? _____ Type: _____

Marital Status: _____ Occupation: _____ Do you exercise Regularly? _____

Have you ever been abused? ☐Yes ☐No If yes, when? _____ Do you feel safe now? ☐Yes☐No

Gynecological History

First day of last Menstrual Period? _____ Age your periods started? _____

Cycle Length (#days from one to the other)	Days of cycle (#days bleeding)	Quality of Flow (ex: heavy, light, clotted)	Problems/issues with cycle (ex: PMS, cramping, acne)

Age at first sexual intercourse? _____ Number of sexual partners in your lifetime? _____

History of sexually transmitted disease? ☐Yes ☐No If yes, what? _____

Current contraception:☐None/Not Sexually Active ☐None/Trying for Pregnancy ☐Condoms

☐Birth Control Pills/Patch/Ring ☐IUD ☐Tubal Ligation/Essure ☐Vasectomy ☐Hysterectomy

Age of Menopause: _____☐Natural Menopause ☐Hysterectomy

When was your last?

Pap smear:☐Yes ☐No Date/Year: _____ History of abnormalities? _____

STD Testing:☐Yes ☐No Date/Year: _____ History of abnormalities? _____

Mammogram:☐Yes ☐No Date/Year: _____ History of abnormalities? _____

Bone Density:☐Yes ☐No Date/Year: _____ History of abnormalities? _____

Colonoscopy:☐Yes ☐No Date/Year: _____ History of abnormalities? _____

Family History

Are there any major health issues with your close relatives? (I.e. Hypertension, High Cholesterol, Diabetes, Cancer)

	Age	Age Deceased	Medical Problems
Mother			
Father			
Sisters			
Brothers			
Maternal Grandmother			
Grandfather			
Paternal Grandmother			
Grandfather			

Thank you for your patience in filling out this form so that we may better know you and understand your healthcare needs.

Physician Notes:

_____
_____
_____
_____
_____