Oak Hills Women's Center, P.A.
Bernard R. Cavazos, Jr., M.D.
Allison R. Cavazos, M.D.
Sarah Lewis, FNP-C

Patient History and Physical

Name: _____

Address: _____

Today's Date: _____ **Date of Birth:** _____

Phone Number: _____ **Cell Phone Number:** _____

Email Address: _____ **Age** _____

Pharmacy Name _____ **Pharmacy Phone #** _____

Street / Cross Section _____ **Pharmacy Fax #** _____

Social History:
Single
Married
Divorced
Widowed

Reproductive History: Total #

Pregnancies: _____
Premature Births: _____
Miscarriages: _____
Abortions: _____
Vaginal Deliveries: _____
C-Sections: _____

Tobacco Use: Yes / No
Any hx of STD's: Yes / No
Any hx of Abnormal Paps: Yes / No

(If yes, please list date of last abnormal pap smear)

Last Menstrul Period: _____
Date of Last Pap Smear: _____
Date of Last Mammogram: _____
Method of Contraception: _____

Office Use Only

Vital Signs:
B/P: _____
Weight: _____
Height: _____

Allergy List: _____

Medication List: _____

Family Medical History:

	Relationship		Relationship
Hypertension:		Cancer:	
Diabetes:		Bleeding Disorders:	
Thyroid Diseases:		Genetic Abnormalities:	
Kidney Problems:		Anemia:	
Bowel Problems:		Breast Disease:	

Past Medical History:

Illness: _____ Date: _____
Illness: _____ Date: _____

Phone: (210) 692-3636
Fax: (210) 692-3668
Website: www.oakhillswomenscenter.com
Email: info@oakhillswomenscenter.com

SEE BACK

Illness: _____ Date: _____

Past Surgical History:

Operation: _____ Date: _____
Operation: _____ Date: _____
Operation: _____ Date: _____
Operation: _____ Date: _____

Additional Notes: _____

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