Williamson Gynecology

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PATIENT HEALTH HISTORY

Name: ____Age: ____ Birth date: ___/___/___ Today's date: ___/___/___
Your Occupation: _______________________________ Primary Care Provider: ________________________________
Who may we thank for this referral: _______________________________
Your email address: ____

Reason for today's visit: Wellness Y N Problem Y N ____

Past Medical and Family History:
Please circle all that apply. Additional boxes available for other medical history not listed.
(P=Patient (you) F=father M=mother C=child S=sibling GM=grandmother GF=grandfather)

Condition		Condition	
Alcoholism	P F M C S GM GF	High cholesterol	P F M C S GM GF
Asthma	P F M C S GM GF	Hypertension	P F M C S GM GF
Bleeding disorder	P F M C S GM GF	Migranes	P F M C S GM GF
Diabetes	P F M C S GM GF	Depression	P F M C S GM GF
Breast cancer	P F M C S GM GF	Seizures	P F M C S GM GF
Ovarian cancer	P F M C S GM GF	Stroke	P F M C S GM GF
Endometrial cancer	P F M C S GM GF	Thyroid disease	P F M C S GM GF
Colon cancer	P F M C S GM GF	Sleep apnea	P F M C S GM GF
Melanoma	P F M C S GM GF	Dementia	P F M C S GM GF
_________________	P F M C S GM GF	_________________	P F M C S GM GF
_________________	P F M C S GM GF	_________________	P F M C S GM GF

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Past Surgeries:

____ ____
____ ____
____ ____
____ ____

List your current Medications: (Prescribed and over the counter) Dosage and directions

____ ____
____ ____
____ ____
____ ____
____ ____

Do you have allergies to medicines? N Y If yes then list:

____ ____
____ ____
____ ____

Social History: Please list below if you are involved in the following activities

Alcohol	N Y	____times per week
Tobacco	N Y	____times per week
Illicit drugs	N Y	____ times per week
Exercise	N Y	____ times per week
Abuse	N Y	____ Past ______________ Current __________________

OB/GYN History:

Have you had a period in the last year? N Y **If yes, please complete these questions:**

Last period (1st day of last period) __/__/__

Are they monthly? Y N Is the flow heavy? Y N

How many days does period last? 0 1 2 3 4 5 6 7 8 9 ___

Do you have pain or cramps? Mild Moderate Severe

Present method of birth control (including vasectomy):____

Have you ever:

Taken hormones: ____________________

Had STD N Y _________________________________

Had abnormal pap N Y Treatment required _______________________________________

Had infertility N Y

Prior pregnancies: Total # pregnancies _____ # miscarriages ____ # abortions____#living children____

#adopted children _____vaginal delivery _____ C-section ____Did you breast feed? ____

TODAY: (Only circle what is a problem for you today) Review of Systems:

General
Sudden weight loss/gain
Fevers/aching
Eye problems

Ear, Nose, Throat, Mouth
Head cold
Sinusitis
Sore throat

Mental Health
Depression
Anxiety
Mood swings

Musculoskeletal
Muscle aches
Back pain/strain
Leg/hip pain

Endocrine
Thyroid problems

Respiratory
Cough
Shortness of breath

Cardiac/vascular
Chest pain
Swelling of legs
Varicose veins
Heart palpitations

Hematologic
Bruising
Swollen glands

Genitourinary
Pain with urination
Problem leaking urine
Urine frequency

Skin
Abnormal mole
Rashes/lesion

GYN
Irregular periods/no periods
Painful periods
Pelvic pain
Vaginal discharge
Hot flashes
Night sweats
STD exposure

Breast
Breast pain
Breast lump

Gastrointestinal
Nausea/Vomiting
Diarrhea
Heartburn
Constipation
Hemorrhoids
Blood in stool

Leave this section blank. To be completed by staff:

Last pap: Date _______ Results ________________

Mammogram: Date ______ Loc _________ Results _________________________

Colorectal screening: Date ____ Results ____________________________

Type of Birth Control: ____

BSE: No ___ Yes ___

Bone Density: Date ___________ Results __________________________

Immunizations: Gardisil ____

Please Sign and Date ____ ____________________

Provider Sign and Date _______________________________________ ____________________