Women's Health Center, P.C.

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1421 Baddour Parkway • Lebanon, Tennessee 37087 • Phone 615/449-6780

HEALTH HISTORY

Date: ____________________

Patient Name: ____________________

Address: ____________________

Phone: ____________________

Age: __________ Date of Birth: ____________________

Occupation: ____________________

Marital Status: ( ) Married ___# Yrs. ( ) Sgl. ( ) Div. ( ) Sep. ( ) Widow

Height: __________ Weight: __________

Reason For Visit:

( ) Yearly Exam
( ) Pregnancy Care
( ) Contraception
( ) GYN Problem Explain: __________
____
( ) Other: __________
____

MENSTRUAL HISTORY

Age at onset of periods: ____________________

Pain with periods: ( ) Yes ( ) No__________

Date of last menstrual period: ____________________

Periods last _______ days   Periods are _______ days apart

Periods are: ( ) Light ( ) Moderate (heavy)

Last period was normal: ( ) Yes ( ) No

PAST HISTORY:

	Patient	Family
Severe headaches	☐	☐
Diabetes	☐	☐
Thyroid problems	☐	☐
Breast problems	☐	☐
High blood pressure	☐	☐
Heart murmur	☐	☐
Heart attack	☐	☐
Rheumatic fever	☐	☐
Asthma or hay fever	☐	☐
Tuberculosis	☐	☐
Stomach or peptic ulcer	☐	☐
Liver disorders	☐	☐
Gall bladder	☐	☐
Chronic diarrhea	☐	☐
Colitis	☐	☐
Hernia	☐	☐
Hemorrhoids	☐	☐
Kidney stone	☐	☐
Veneral disease	☐	☐
Back trouble	☐	☐
Arthritis	☐	☐
Bone disease	☐	☐
Varicose veins	☐	☐
phlebitis (clots in veins)	☐	☐
Skin disease	☐	☐
Anemia	☐	☐
Bleeding or clotting disorder	☐	☐
Muscle disease	☐	☐
Convulsions	☐	☐
Nervous disorders	☐	☐
Cancer	☐	☐
Birth defects	☐	☐
Inherited disorder	☐	☐
Other	☐	☐

For Physician's Use Only

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Name ______________________________

DOB ______________________________

OBSTETRICAL HISTORY

No. of Pregnancies_______ No. of Deliveries_______ No. of Miscarriages_______

Please list each pregnancy:

YEAR BIRTH WEIGHT PREMATURE ( ) YES ( ) NO ( ) PROBLEMS

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

CONTRACEPTION

Are you currently practicing birth control? ( ) Yes ( ) No If yes, what method? ______________

Are you satisfied with this method? ( ) Yes ( ) No

PRIOR SURGICAL PROCEDURES

Name of Procedure	Year	Place	Surgeon
1.			
2.			
3.			
4.			
5.			

OTHER HOSPITALIZATIONS

For What Reason	Year	Place	Attending Physician
1.			
2.			
3.			
4.			

CURRENT MEDICATIONS

Name of Drug	Dosage	Reason Taken	Prescribing Doctor
1.			
2.			
3.			
4.			

DRUG ALLERGIES

Name of Drug	How manifested?
1.	
2.	
3.	
4.	

Date: ______________________ Signature: ______________________________

100-WHC