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: ______________________