

**ADVANCED WOMEN'S CARE CENTER, S.C.**

**Medical History**

Today's Date:

Name: \_\_\_\_\_ Date of Birth:     /     /     Age: \_\_\_\_\_

Who referred you to our practice: \_\_\_\_\_

**Have you or anyone in your family had any of the following:**

Medical Condition	You	Your Family	Please Explain
Anemia/Blood Disorder			
Arthritis/Joint Pain			
Asthma/Lung Disease			
Breast Disease/Breast Cancer			
Cancer    Type:			
Diabetes			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Liver or Kidney Disease			
Mental Health Disorder			
Migraines/Headaches			
Osteoporosis			
Seizures/Epilepsy			
Stomach Disorder			
Stroke/Blood Clots			
Thyroid Disease			
Urinary Infections			
Other Disorder			

Obstetric History	Weeks Pregnant	Date	Weight	Name	Hospital/Doctor	Complications
Delivery (type)						
Miscarriage						
Abortion						
Ectopic Pregnancy						
Still Birth						

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**Please list all previous Injuries, Hospitalizations and Surgeries**

Year	Injury, Hospitalization, Surgery	Complications

**Gynecologic History**

First day of your last period: \_\_\_\_\_  
Age when periods first began: \_\_\_\_\_  
Are your periods regular: \_\_\_\_\_  
Are you in menopause: \_\_\_\_\_  
How often do you get your period: \_\_\_\_\_ days apart.  
Period lasts how many days: \_\_\_\_\_  
Is the flow: \_\_\_\_\_ light \_\_\_\_\_ moderate \_\_\_\_\_ heavy  
During you period do you have:  
\_\_\_\_\_ cramps \_\_\_\_\_ pain \_\_\_\_\_ bloating \_\_\_\_\_ PMS \_\_\_\_\_ headaches  
Spotting or bleeding between periods: \_\_\_\_\_  
Pain/bleeding with intercourse: \_\_\_\_\_

Have you ever had any of the following:

_____ abnormal pap smear	_____ bacterial vaginosis	_____ yeast	_____ chlamydia
_____ HPV/genital warts	_____ pelvic infection	_____ herpes	_____ gonnorrhea
_____ syphilis	_____ uterine tumors	_____ ovarian cysts	
_____ endometriosis	_____ colposcopy	_____ LEEP/conization	
_____ infertility	_____ endometrial biopsy	_____ other	

**Birth Control History**

What birth control are you currently using: \_\_\_\_\_  
What have you used in the past: \_\_\_\_\_ Patch \_\_\_\_\_ Nuva Ring \_\_\_\_\_ Pill: type: \_\_\_\_\_  
\_\_\_\_\_ Depo Provera \_\_\_\_\_ Diaphragm \_\_\_\_\_ Condom \_\_\_\_\_ Fertility Awareness  
\_\_\_\_\_ Spermicides \_\_\_\_\_ Abstinence \_\_\_\_\_ IUD \_\_\_\_\_ Tubal Ligation \_\_\_\_\_ Vasectomy  
What method would you like to use now: \_\_\_\_\_

**Sexual History**

\_\_\_\_\_ Never been sexually active \_\_\_\_\_ currently having sex \_\_\_\_\_ not currently  
\_\_\_\_\_ Age at first intercourse  
How many partners have you had: \_\_\_\_\_ 0 \_\_\_\_\_ 1 \_\_\_\_\_ 2-5 \_\_\_\_\_ more than 5

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**Please list all current medications, include non-prescription, vitamins,& herbs:**

Medication	Dosage	What taken for	When begun	Any side effects

**Please list all allergies:**

Medications \_\_\_\_\_ Reaction \_\_\_\_\_  
 Environmental \_\_\_\_\_ Reaction \_\_\_\_\_  
 Foods \_\_\_\_\_ Reaction \_\_\_\_\_  
 Are you allergic to: Latex  Yes  No  
 Iodine  Yes  No  
 KY gel  Yes  No

**Social History**

Living Situation:  Single  Married  Divorced  Widowed  
 Separated  Live Alone  Domestic Partnership  
 Live with Parent(s)  Live with Room-mate(s)

Tobacco Use:  Never  Quit  Currently Smoke  pack(s) a day  
 Alcohol Use:  Never  Drinks per week  
 Recreational Drugs:  No  Yes Type(s) \_\_\_\_\_

**Health Screening**

Immunization up to date:  Yes  No  
 Year of last Tetanus vaccine \_\_\_\_\_  
 Mammogram:  Yes  No  Date \_\_\_\_\_  Normal  Abnormal  
 DEXA (bone scan):  Yes  No  Date \_\_\_\_\_  Normal  Abnormal  
 Pap Smear:  Yes  No  Date \_\_\_\_\_  Normal  Abnormal  
 Lipids (Cholesterol)  Yes  No  Date \_\_\_\_\_  Normal  Abnormal  
 Colonoscopy  Yes  No  Date \_\_\_\_\_  Normal  Abnormal  
 TSH (thyroid):  Yes  No  Date \_\_\_\_\_  Normal  Abnormal

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_ Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_