



Southern Indiana
Women, P.C. *Physicians for*

PATIENT HEALTH HISTORY

Today's Date ___/___/___

Name _____ Maiden Name _____

Address _____
Street Address Apt./Lot City/State/Zip Code

Home Phone No. (____) _____ Work Phone No. (____) _____

Date of Birth ___/___/___ Age ____ [] Single [] Married [] Separated [] Divorced [] Widowed

Employer _____ Employer Phone No. (____) _____ Occupation _____

EDUCATION: ____ years High School ____ years College ____ years Post-Graduate

FAMILY HISTORY: Were you adopted? Yes No

	Name	Age	Health Problems	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
Brothers	_____	_____	_____	_____

Did any of your blood relatives ever have:

- ___ Diabetes ___ Cancer ___ Inherited Disorders ___ Clotting/Bleeding problems
- ___ Heart Disease ___ Strokes ___ Birth Defects
- ___ High Blood Pressure ___ Epilepsy ___ Breast Disease

INJURIES (What and When)

1. _____
2. _____
3. _____
4. _____
5. _____

PREVIOUS HOSPITALIZATIONS (Why and When)

1. _____
2. _____
3. _____
4. _____
5. _____

PREVIOUS SURGERIES (What, Where and Why)

1. _____
2. _____
3. _____
4. _____

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Medication Allergies _____

Other Allergies _____

Current Medications _____

Do you Smoke? Yes No _____ packs per day _____ years Alcohol consumption? _____ drinks per week

Caffeine (What and How Much?) Coffee / Tea / Soda / Chocolate _____ per week

CHECK IF YOU HAVE EVER HAD:

- | | | |
|-----------------------------|---|-------------------------------------|
| ____ Measles | ____ Stomach Problems | ____ Weight Gain/Loss |
| ____ German (30day) Measles | ____ Gall Bladder Disease | ____ Kidney Disease |
| ____ Chicken Pox | ____ Yellow Jaundice | ____ Kidney or Bladder Infection |
| ____ Tuberculosis | ____ Hepatitis | ____ Involuntary Loss of Urine |
| ____ Pneumonia | ____ Bowel Problems | ____ Pain on Urination |
| ____ Rheumatic Fever | ____ Change in Bowel Habits | ____ Frequent Urge to Urinate |
| ____ Heart Disease | ____ Diabetes | ____ Pressure with Urination |
| ____ Chest Pain | ____ Blood in Stool | ____ Blood in Urine |
| ____ High Blood Pressure | ____ Varicose Veins | ____ Changes in Facial or Body Hair |
| ____ Mumps | ____ Phlebitis or Clots in Vein | ____ Hot Flashes |
| ____ Breathing Difficulty | ____ Excessive Bleeding w/ Surgery/Injury | ____ Genital Herpes/Warts |
| ____ Asthma | ____ Migraine Headaches | ____ X-rays |
| ____ Chronic Lung Disease | ____ Hearing Problems | ____ Breast Disease/Problems |
| ____ Pulmonary Embolus | ____ Thyroid Problems | ____ Other Problems |

GYNECOLOGICAL HISTORY: (Leave questions that you do not want to answer blank.)

Age when periods started _____ Last period began _____ Normal? Yes No

How often do they occur? _____ How long do you flow? _____ Do you bleed between periods? Yes No

Are you bothered by Clots? Yes No Cramps? Yes No Bloating? Yes No Mood Changes? Yes No

Date of your last PAP? _____ Ever had an abnormal PAP? Yes No When? _____

Did your mother take DES or any hormone medication when pregnant with you? Yes No

Are you having intercourse? Yes No Age of first intercourse _____ Are you using birth control? Yes No

Problems with sex _____ Do you perform breast self-exams? Yes No

Have you ever had a D&C? Yes No When & Why? _____

PREGNANCIES:

Any problems becoming pregnant? _____

List pregnancies delivered:

Date	Type of Delivery	Sex	Weight	Health	Name
1. _____	_____	_____	____ lbs. ____ ozs.	_____	_____
2. _____	_____	_____	____ lbs. ____ ozs.	_____	_____
3. _____	_____	_____	____ lbs. ____ ozs.	_____	_____
4. _____	_____	_____	____ lbs. ____ ozs.	_____	_____

Number of term deliveries _____ Premature _____ Miscarriages _____ Abortions _____ Stillbirths _____

No. of living children _____ Birth defects _____ Complications _____

Date of last complete physical examination _____

Reason(s) for being seen today _____

Any particular questions we can discuss today _____