PHYSICIANS TO WOMEN, INC.

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www.ptow.com

HEALTH HISTORY

Today's Date ________________

PATIENT NAME ____________________________________ **Birthdate**____/____/_____ **AGE**__________

Preferred name ______________________________ **Preferred pharmacy** ______________________________

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY. THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE.

PRIMARY CARE PROVIDER: ____

Other Doctors involved with your care: ____

____

I. PAST MEDICAL HISTORY—Have you ever had the following?

❑ None

	Dates		Dates		Dates
❑ Anemia		❑ Cancer ❑ Type:		❑ Kidney Disease	
❑ Anorexia/bulimia		❑ Depression		❑ Migraines	
❑ Anxiety		❑ Diabetes		❑ Osteopenia or Osteoporosis	
❑ Arthritis		❑ Fibromyalgia		❑ Seizures	
❑ Asthma		❑ GERD - Gastroesophageal Reflux Disease		❑ Sickle Cell disease or trait	
❑ Blood Clot (DVT/PE) and/ or clotting disorder		❑ Heart Disease		❑ Stroke	
❑ Blood Transfusion		❑ Hepatitis		❑ Stomach Ulcer	
❑ Breast Cancer		❑ Hypertension (High blood pressure)		❑ Thyroid Disease	
❑ Breast Disease (Fibrocystic, cysts, lump)		❑ Irritable bowel Syndrome (IBS)		❑ Anesthesia complications	
❑ Broken bones		❑ Liver disease		❑ Other	
❑ Bowel disease		❑ Lung disease			

II. HEALTH MAINTENANCE

	Dates		Dates		Dates
❑ Last Pap Smear		❑ Last Mammogram		❑ Last Colonoscopy	
❑ Last Bone Density Test		❑ Last STD screening		❑ Last Check-up	
❑ Flu Shot		❑ HPV Vaccine		❑ Tetanus Shot	

III. CURRENT MEDICATIONS

❑ None

Name	DOSE	How often?
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

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IV. ALLERGIES TO MEDICATIONS

❑ None

________________________ Reaction ________________________

________________________ Reaction ________________________

________________________ Reaction ________________________

V. SURGICAL HISTORY

❑ None

	Dates		Dates
❑ Appendectomy		❑ Hysterectomy ❑ Vaginal ❑ Abdominal ❑ Laproscopic	
❑ Breast Surgery (Biopsy, Lumpectomy, Mastectomy) ❑ Left ❑ Right		❑ Joint Surgery or replacement	
❑ Cervix procedure (LEEP, Freezing, conization)		❑ Laparoscopy	
❑ Cosmetic ❑ Type		❑ Myomectomy (removal of uterine fibroids)	
❑ C-Section		❑ Ovary removal ❑ Left ❑ Right	
❑ D&C		❑ Surgery for prolapse or urinary incontinence ❑ Vaginal sling ❑ Mesh	
❑ Endometrial Ablation (uterus procedure to control bleeding)		❑ Tonsillectomy	
❑ Hernia Repair ❑ Inguinal/groin ❑ Umbilical		❑ Tubal ligation (tubes tied)	
❑ Other surgery (please list):			

VI. SOCIAL HISTORY

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Widowed ❑ Partnered

Smoking/tobacco/vapor: ❑ Never ❑ Past ❑ Current (list below)

Type ________________________ Amount ________________________

If former smoker: Type/Amount ________________________ Date quit: __________ Years of use: __________

Alcohol ❑ Never ❑ Past ❑ 1-4 month ❑ 1-3 week ❑ 4+ per week

How many alcoholic drinks do you have when you drink? ❑ 1-2 ❑ 3-4 ❑ 5-6 ❑ 7+

Have you used drugs recreationally or for non-medical reasons? ❑ Yes ❑ No

If yes: dates of last use? ❑ Marijuana ______________ ❑ Cocaine ______________

❑ Heroin ______________ ❑ Pain killers / opiates ______________ ❑ Other ______________

Occupation ____

Have you ever been verbally, emotionally, sexually, or physically assaulted, abused or threatened by your partner or anyone else? ❑ Yes ❑ No

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VII. GYNECOLOGIC HISTORY:

	Dates		Dates		Dates
❑ Abnormal Pap Smear		❑ Herpes		❑ Polycystic ovaries (PCOS)	
❑ Chlamydia		❑ HIV / AIDS		❑ Pelvic Infection / PID	
❑ Endometriosis		❑ HPV		❑ Syphilis	
❑ Genital Warts		❑ Infertility		❑ Uterine fibroids	
❑ Gonorrhea		❑ Ovarian cysts		❑ Trichomonas	

Age of 1st period ________________

Are you sexually active? ❑ Yes ❑ No Age at first intercourse ___________

Is your sexual activity with: ❑ Men ❑ Women ❑ Both

Pain with intercourse ❑ Yes ❑ No

Bleeding with intercourse ❑ Yes ❑ No

Have you had a new sexual partner in the past year? ❑ Yes ❑ No

Menopausal: Age of menopause_________ Bleeding after menopause? ❑ Yes ❑ No

Have you used hormone replacement therapy? ❑ Current ❑ Past ❑ Never

Type _____________________ Date ________________ How long? ________________

***If menopausal, please skip to section VIII (Obstetric History)

Date of last menstrual period ________________ #Days between period ❑ <25 ❑ 25-35 ❑ >35

#Days bleeding ___________ Bleeding/Spotting between periods ❑ Yes ❑ No

Flow: ❑ Light ❑ Moderate ❑ Heavy ❑ Clots

Menstrual Cramps: ❑ Never ❑ Sometimes ❑ Always ❑ Mild ❑ Moderate ❑ Severe

Do you use medications for cramping?____

Have you had to miss work/school because of cramping or other symptoms? ❑ Yes ❑ No

Do you use birth control? ❑ Yes ❑ No *Please check all that apply:*

❑ Condoms ❑ Withdrawal / "pull out" ❑ Rhythm / natural method ❑ Pill

❑ NuvaRing ❑ Nexplanon implant ❑ Patch ❑ DepoProvera

❑ IUD ❑ Tubes tied ❑ Vasectomy ❑ Other ___________

VIII. OBSTETRIC HISTORY:

Total pregnancy #_____ Full Term # _____ Premature # _____ Living children # _____

Miscarriages # _____ Terminated / abortions # _____ Ectopic # _____ Multiples (twin, triplet) # _____

	Date of delivery	Weight	Gender	Type of delivery (vaginal, forceps, vacuum, C-section	Complications	Location
1						
2						
3						
4						
5						
6						

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Please indicate if any of these pregnancy related conditions apply to you:

❑ Birth Defect Type:	❑ High blood pressure	❑ Preterm labor
❑ Cerciage	❑ Injury to baby at delivery	❑ Preterm rupture of membranes (water broke early)
❑ Fetal growth restriction (baby not growing normally)	❑ Placenta abnormality ❑ Abrubtion ❑ Previa	❑ Shoulder dystocia (baby's shoulder got stuck and needed extra maneuvers at delivery)
❑ Fluid problems (too much or too little)	❑ Post-partum hemorrhage (excessive bleeding after delivery)	❑ Third or fourth degree tear at delivery
❑ Gestational diabetes	❑ Preterm delivery	❑ Vaginal delivery after c-section (VBAC)
❑ Other		

IX. FAMILY HISTORY (please list mother, father, siblings, grandparent, etc.)

❑ Unknown ❑ Adopted

	None	Mother	Father	MGM	MGF	PGM	PGF	Sibling	Child	Other
Alcoholism or drug use										
Birth defects										
Blood clot and/or clotting disorder										
Breast cancer										
Colon cancer										
Colon polyps										
Cystic fibrosis										
Developmental problems										
Diabetes										
Down syndrome										
Genetic problems or condition										
Heart disease or defect										
Hypertension (High blood pressure)										
Kidney problems										
Mental illness										
Osteoporosis / hip fracture										
Ovarian cancer										
Stroke										
Uterine (endometrial) cancer										
Other cancer (List:)										
Other										