Aurora Womancare, PC

New Patient Health History

Full Name:_____Nickname:_____

Date of Birth: _____

Occupation: _____Marital Status:_____

Medicines you take (including vitamins and OTC meds) please list name, dose and frequency of use)_____

_____

Allergies (to medications and other; please indicate particular allergic reaction i.e., hives)_____

Past Surgeries (including gynecologic surgeries and biopsies), reason, and age at time of surgery

_____

_____

Past Hospitalizations, reason, and age: _____

_____

Past and current medical conditions (please indicate age at diagnosis of condition and whether condition is current or resolved):

__ Anemia/other blood disorder (please specify)_____
__Asthma/other respiratory disease (please specify)_____
__High Blood Pressure_____
__High Cholesterol_____
__Heart Condition_____
__Thyroid Condition_____
__Neurologic Condition (please specify)_____
__Diabetes_____
__Headaches_____
__Depression_____
__Anxiety_____
__Eating Disorder_____
__Alcohol/Drug abuse or addiction_____
__Sinus Problems_____
__GERD(heartburn)_____
__Arthritis_____
__Abnormal Mammogram/Breast problem_____
__Cancer(please specify)_____
__Other(please specify)_____

_____

Family History: Do any relatives have any of the above medical conditions, or other significant diagnoses? Please list who, what they have or had, age at diagnosis if known, and age and cause of death, if applicable.

_____

_____

_____

Immunization History:

Normal Childhood Vaccinations? Yes No

Last Tetanus Shot_____ Hepatitis B Series Done? Yes No

Hepatitis A Series Done? Yes No Annual Flu Shot Yes No

Have you ever had a Pneumonia shot? Yes No When?_____

OB/GYN history: Age of first period_____ Age of Menopause____ if applicable

Periods are: Heavy / Medium / Light Regular/Irregular Frequency: _____

Current and past contraception use (and any side effects:)_____

_____

If menopausal, current and past hormone use (and nay negative side effects):_____

_____

Last pap smear_____ Have you ever had an abnormal pap smear? Yes No

Diagnosis_____Treatment_____Follow up_____

Last mammogram and result_____

# of pregnancies____ # of children born alive____ # of miscarriages_____

# of abortions____ # of C-sections___ # of vaginal deliveries___ of living children____

Smoking history: N/A At what age did you start smoking?___ At what age did you stop(if applies)?___ Average amount per week____ Current amount per week ____

Would you like to quit? Yes No

Alcohol use: How many drinks per week do you typically consume? _____

Current or history of any other drug use? Yes No If so, what , and when did you use it?

_____

Current symptoms(please circle any): Change in weight (unintentional) Fever

Fatigue Weakness Poor Vision Allergies Sinus Problems Sore Throat Cough

Wheezing Swollen Glands Chest Pain Palpitations Dizziness Nausea/Vomiting

Reflux Abdominal pain Bowel Changes Blood in Stool Joint pain Back pain

Muscle Aches Vaginal Discharge Change in periods Heavy Bleeding

Urinary Symptoms Headaches Numbness/Tingling Fainting Depression Anxiety

Substance Abuse Other_____