Aurora Womancare

New Patient Health History

Full Name: _____Nickname: _____

Date of Birth: _____ Marital Status: _____

Occupation: _____

Medicines you take (including vitamins and OTC meds) please list by 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: _____

_____

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 Headaches

Urinary Symptoms Numbness Tingling Fainting Depression Anxiety

Substance Abuse Other_____

Immunization History

Normal Childhood Vaccinations? **Yes** **No** Annual Flu Shot? **Yes** **No** Covid Vaccine? **Yes** **No**

Hepatitis A Series done? **Yes** **No** Hepatitis B Series Done? **Yes** **No** Prevnar 13? **Yes** **No**

Last Tetanus Shot_____ Have you ever had a Pneumonia shot? **Yes** **No** When? _____

Past and Current Medical Conditions

Please indicate age at diagnosis and whether condition is current or resolved.

Symptom	Age	Current	Resolved	Symptom	Age	Current	Resolved
High Blood Pressure				High Cholesterol			
Heart Condition				Thyroid Condition			
Diabetes				Headaches			
Depression				Anxiety			
Eating Disorder				Sinus Problems			
GERD				Arthritis			
Abnormal Mammogram/Breast Problem				Alcohol/Drug Abuse or Addiction			
Anemia or Other Blood Disorder (please specify)				Cancer (please specify)			
Asthma/Respiratory Disease (please specify)				Other (please specify)			
Neurological Condition (please specify)							

Family History

Do any relatives have any of the above medical conditions, or other significant diagnoses? Please list two, what they have or had, age of diagnosis (if known), age and cause of death, if applicable.

_____

_____

_____

OB/GYN History

Age of First period? _____ Periods are**: Heavy / Medium / Light Regular / Irregular** Frequency: _____

Age of Menopause? (if applicable) _____ Current and past Contraception use (and any side effects) _____

If menopausal, current and past hormone use (and any side effects) _____

Last Pap Smear: _____ Abnormal Pap Smear: **Yes No** Diagnosis: _____ Treatment: _____

Last Mammogram and result: _____

# of pregnancies: _____ #of children born alive: _____ # of miscarriages: _____ # of abortions: _____

Smoking History and Alcohol Use

What age did you start to smoking? _____ N**/A** What age did you stop smoking (if applicable)? _____ **N/A**

Average Amount per week? _____ Current amount per week? _____ Would you like to quit? **Yes No**

How much Alcohol do you typically consume per week? _____

Current or past drug use? **Yes No If** so, what, and when did you use it? _____