B E D F O R D
# Women's Care
A S S O C I A T E S, P. A.

| **First Name:** | **Last Name:** | **DOB:** |
|---|---|---|
| **Work Status:** Full time Part time Unemployed | **Occupation:** | |

## Medical History

***Check all that apply. Have you ever had:***

| | Condition | | |
|---|---|---|---|
| ☐ | Asthma or breathing problems | Details: | Month/Year Diagnosed: |
| ☐ | Pneumonia or Tuberculosis (Circle) | Month/Year Diagnosed: | |
| ☐ | Seizures or Epilepsy | Details: | Month/Year Diagnosed: |
| ☐ | Migraine Headaches | Month/Year Diagnosed: | |
| ☐ | Frequent non-migraine headaches | Date of onset: | Frequency: |
| ☐ | Neurological Disorder | Details: | Month/Year Diagnosed: |
| ☐ | Visual/Hearing impairment | Details: | Month/Year Diagnosed: |
| ☐ | High Blood Pressure | Month/Year Diagnosed: | |
| ☐ | High Cholesterol | Month/Year Diagnosed: | |
| ☐ | Heart Murmur | Month/Year Diagnosed: | |
| ☐ | Mitral Valve Prolapse | Month/Year Diagnosed: | |
| ☐ | Heart or cardiac problems | Details: | Month/Year Diagnosed: |
| ☐ | Varicose Veins or Circulatory problems | Details: | Year of Onset: |
| ☐ | Urinary Tract or Kidney infection/stones | Month/Year Diagnosed: | |
| ☐ | Urinary Incontinence | Details: | Symptom onset: |
| ☐ | Thyroid Disorder or Goiter | Details: | Month/Year Diagnosed: |
| ☐ | Diabetes or Endocrine Disorder (circle) | Details: | Month/Year Diagnosed: |
| ☐ | Gallbladder Disease/Stones | Details: | Month/Year Diagnosed: |
| ☐ | Refulux/Digestive/Abdominal Concerns | Details: | Month/Year Diagnosed: |
| ☐ | Hemorrhoids | Details: | Month/Year Diagnosed: |
| ☐ | Liver Disease | Details: | Month/Year Diagnosed: |
| ☐ | CANCER OF ANY TYPE | Details: | Month/Year Diagnosed: |
| ☐ | Anemia | Month/Year Diagnosed: | |
| ☐ | Blood Disorder or Clotting Disorder (circle) | Details: | Month/Year Diagnosed: |
| ☐ | Skin Disease | Details: | Month/Year Diagnosed: |
| ☐ | Chicken Pox | Month/Year Diagnosed: | |
| ☐ | Arthritis or Musculoskeletal Disorders | Details: | Month/Year Diagnosed: |
| ☐ | Osteoporosis/Osteopenia | Month/Year Diagnosed: | |
| ☐ | Depression | Month/Year Diagnosed: | |
| ☐ | Anxiety | Month/Year Diagnosed: | |
| ☐ | Psychological Disorder | Month/Year Diagnosed: | |
| ☐ | Anorexia/Bulemia | Details: | Month/Year Diagnosed: |

## Medical History Continued

***Check all that apply. Have you ever had:***

| | | | |
|---|---|---|---|
| ☐ | Ovarian Cysts | Details: | Month/Year Diagnosed: |
| ☐ | Abnormal Pap Smears | Details: | Month/Year Diagnosed: |
| ☐ | Gynecological Conditions | Details: | Month/Year Diagnosed: |
| ☐ | OTHER: | Details: | Month/Year Diagnosed: |

Allergies:

Are you allergic to latex? NO YES Reaction:

Are you allergic to any medications or foods? NO YES

| | |
|---|---|
| Medication/Reaction: | Medication/Reaction: |
| Medication/Reaction: | Medication/Reaction: |

Current Medications (Including any over the counter or herbal supplements):

| | |
|---|---|
| Medication/Dose: | Medication/Dose: |
| Medication/Dose: | Medication/Dose: |
| Medicaton/Dose: | Medication/Dose: |
| Medicaton/Dose: | Medicaton/Dose: |

## SURGICAL HISTORY

***Have you ever had any surgery - minor or major?*** NO YES

| | |
|---|---|
| Surgery: | Date: |
| Surgery: | Date: |
| Surgery: | Date: |
| Surgery: | Date: |
| Surgery: | Date: |
| Surgery: | Date: |

**Have you ever had any complications after anesthesia?** NO YES Details:

Gynelogical/Reproductive History:

| | |
|---|---|
| Age of first menstrual period: | Date of your last menstrual period (LMP): |
| Number of days between menses: | Certainty of LMP date (circle): Sure Unsure |
| Menses duration: | Breakthrough bleeding(circle)? NO YES |
| Flow (circle): Light Medium Heavy | Clots (Circle)? NO YES |
| Number of tampons used per cycle: | Cramps (circle)? NO YES |
| Number of Pads used per cycle: | Birth Control Method: |

Are you planning a pregnancy in the next 6-12 months? NO YES

Are you sexually active? NO YES

Have you ever had an STD?: ___Chlamydia___Gonorrhea___Syphilis___Genital Warts___Herpes__Trichomoniasis__PID

Do you have a history of herpes exposure?

Number of Lifetime sexual partnners: (circle) More than 5 Less than 5 One

Age of first sexual intercourse:

Do you perform a monthly self breast exam? NO YES

Did your mother take DES while pregnant with you? NO YES

Have you ever had any trouble getting pregnant? NO YES Details:

## Obstetrical History - Previous pregnancies

| **Date** m/d/y | Type: Miscarriage/Ectopic Abortions/Stillborns Vaginal/C-Section | Sex Weight Condition of baby | Hours of Labor | Type Anesthesia | Months Breast Fed | Place of Delivery | Complications |
|---|---|---|---|---|---|---|---|
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## Social History

Marital status: Single Living Together Engaged Married

How is your partner/spouses health? Health Concern(s):

What is your sexual preference: Heterosexual Homosexual Bisexual

Have you ever smoked?

- ☐ NO
- ☐ Yes/Currently: How many cigarettes do you smoke a day?
  What age did you start smoking?
- ☐ Yes/History: For how long did you smoke?
  How much did you smoke per day during that time?

Do you consume alcoholic beverages? NO YES How many beverage per week/month?

Do you drink caffeine? NO YES How many beverages per day?

Do you use recreational/street drugs? NO YES What drugs/how often?

Have you ever had a legal or illegal drug abuse problem?

Do you exercise regularly? NO YES If Yes, how often?

Do you consume dairy products? NO YES If yes, how many servings per day?

Do you wear your seatbelts? NO YES

Do you have a new sexual partner? (Circle) NO YES Decline to answer

Are you a victim of Abuse? No Yes Type: sexual physical verbal emotional

## Family Medical History:

***Check all that apply. Indicate which family member : Mother, Father, Sibling, Maternal/Paternal Family member***

- ☐ Birth Defects — Details/Family Member(s):
- ☐ High Blood Pressure — Details/Family Member(s):
- ☐ Stroke — Details/Family Member(s):
- ☐ Heart Attack or Heart Disease — Details/Family Member(s):
- ☐ High Cholesterol — Details/Family Member(s):
- ☐ Cancer — Details/Family Member(s):
- ☐ Thyroid Disease/Endocrine Disease — Details/Family Member(s):
- ☐ Diabetes — Details/Family Member(s):
- ☐ Seizures/Epilepsy — Details/Family Member(s):
- ☐ Kidney Disease — Details/Family Member(s):
- ☐ Mental Ilness — Details/Family Member(s):
- ☐ Blood Disease — Details/Family Member(s):
- ☐ Osteoporosis — Details/Family Member(s):
- ☐ Twins — Details/Family Member(s):
- ☐ Other — Details/Family Member(s):

***Is there anything else regarding your person/surgical/family history that you think we should know? NO YES***

**Details:**