# Hamblen Women's Care

## Patient Information

**Name:**_____ **DOB:**_____

**Medication Allergies:**_____

**Name of Pharmacy:**_____ **Phone:**_____

**Address:**_____

**Reproductive History:**

Age onset of periods:_____ 1st day of last menstrual period:_____

How many days of flow:_____ How often do periods occur:_____

Clots with period:_____Y_____N Is flow:_____Light_____Medium_____Heavy

Current Birth Control_____

Age of Menopause:_____

**GYN:** Last Pap_____ Abnormal Pap:_____Treatment:_____

Past History Sexually Transmitted Infection:_____

Breast: Last Mammogram_____Abnormal Mammogram_____

Last Colonoscopy_____Last Bone Density_____

**Pregnancy History:**

Total Pregnancies:_____

Full Term_____Pre Term_____Miscarriage_____# of Live Births_____# of Living Children_____

**Pregnancy Details:**

| Date Month, Date, Year | Length of Pregnancy in Months | Hours in Labor | Baby's Weight | Sex | C/S or Vaginal |
|---|---|---|---|---|---|
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Were there any complications?_____

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**Please Circle any Medical Problems:**

| | | |
|---|---|---|
| High Blood Pressure | Measles | Psychological Disorder |
| Heart Disease | Mumps | Rheumatic Fever |
| Diabetes | Chicken Pox | Tuberculosis |
| Liver Disorder | Thyroid | Blood Disorder |
| Cancer (Type)_____ | Asthma | Blood Transfusion |
| Urological Disorder | Kidney Disease | Hemorrhoids |

**Please Circle any Surgeries & list the date:**

| | | |
|---|---|---|
| Appendix_____ | Gallbladder_____ | Breast_____ |
| Ovary_____ | Tubal or Essure_____ | Hysterectomy_____ |
| Kidney Stones_____ | Tonsils_____ | Tumors (Type)_____ |
| Vagina Repair_____ | Varicose Veins_____ | C Section_____ |
| Hernia_____ | D & C _____ | Hemorrhoids_____ |
| Cautery of Cervix_____ | Chest_____ | Conization of Cervix_____ |
| Spine_____ | Any other_____ | |

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**Medications you are taking:**

| Medicine | Dose | Frequency |
|---|---|---|
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| | | |
| | | |
| | | |
| | | |
| | | |

**Family History:** (**Please specify** what family member such as mother, father, brother, sister, aunt, uncle, paternal or maternal grandparents, etc.)

Gynecological Cancer_____ Breast Cancer_____

Colon Cancer_____ Heart Disease_____

Hypertension_____ Diabetes_____

Thyroid_____ Birth Defects (Type)_____

**Social History:**

Do you use Tobacco?_____Y_____N_____# per day_____

Do you drink alcohol?_____Y_____N_____# per day_____# per week_____

Do you use drugs?_____Y_____N_____What type?_____

Last grade of school completed?_____

Do you work?_____Y_____N_____where_____

Do you exercise?_____Y_____N_____

Do you wear your seatbelt?_____Y_____N_____

Marital Status:_____

Were you in the military?_____

Is Violence at home a concern?_____Y_____N_____

Have you ever been abused

Mentally_____Y_____N_____

Physically_____Y_____N_____

Sexually_____Y_____N_____

Family Doctor_____

**Reason for Visit:**

_____

_____

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