

Women's Health Care of Southern Indiana, LLC
Patient History

Date: _____

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ ext. _____

Cell Phone (____) _____

Date of Birth _____ Age _____ Marital Status Single _____ Married _____

Primary Care Dr. _____ Social Security Number _____ - _____ - _____

Employer _____ Full Time Part Time

Are you a student? Yes _____ No _____ Full Time Part Time

Do you have an Advanced Directive? Yes No

When was your last Tetanus shot? _____

Emergency Contact: Name _____ Relationship: _____
Phone (____) _____ (____) _____

What is the reason for your visit today? _____

HPI:(Dr. use) _____

Medical History None

Please list any medical problems that you have, the physician taking care of you and how they are treated.

Date	Medical Problem	Physician

Surgical History None

List all surgeries you have had including breast biopsies, tonsillectomy, appendectomy, tubal ligation.

Date	Operation	Diagnosis	Hospital/MD

Gynecologic History

Date of last menstrual period: _____ Menopausal Hysterectomy

Length of cycle from first day to first day each month: _____ days Regular Irregular

Number of days you bleed: _____ days Heavy Moderate Light

How old were you when you had your first period? _____

Have you ever had an abnormal Pap test? Yes No

Have you ever had a sexually transmitted disease? Yes No

What do you use to keep from getting pregnant? Nothing Vasectomy Condoms Tubal ligation

IUD Diaphragm Birth Control Pills Patch Abstinence

Date/place of last Pap test: None _____ Mammogram _____

Are you sexually active? Yes No

Do you have pain with intercourse? Yes No

Pregnancy History: No pregnancies

Number of times pregnant _____ (includes current pregnancy) Full term births _____ Premature births _____

Elective termination _____ Miscarriages _____ Ectopic pregnancies _____

Please list your pregnancy history:

Date	Length of preg. In weeks	Vaginal or C-section	Sex and weight	Hospital/Dr.	Complications

Medications

List all medications that you take with the dose and timing: None

Drug	Dose	Frequency	Reason for Med.	Prescribing MD

Allergies: List all adverse reactions or allergies you have to medications and what happened. None

Family History: Adopted

	Current Age	Age at death	Health problems or cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
Sisters	_____	_____	_____

Social History

How much alcohol do you drink/week? _____

Do you smoke? Yes No Amount/day _____ How many yrs. _____

Occupation: _____

Temp - _____ HR- _____

BP - _____ Height- _____ Weight- _____ Waist- _____ Hips _____

Systems Review:**Gastroenterology**

	Current	Past
Chronic Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Chronic constipation	<input type="checkbox"/>	<input type="checkbox"/>
Persistent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Bloody/Black stools	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>

Constitutional

Recent weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>

Urology

Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>

Female Reproductive

Heavy Periods	<input type="checkbox"/>	<input type="checkbox"/>
Frequent yeast infections	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal itching	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal discharge	<input type="checkbox"/>	<input type="checkbox"/>
More than 2 periods a month	<input type="checkbox"/>	<input type="checkbox"/>

Assessment/Plan

1.)

2.)

3.)

4.)

Physical Exam

	Default	Other
General	_____	
HEENT	_____	
Neck	_____	
Heart	_____	
Chest	_____	
Breast	_____	
Abdomen	_____	
Scars	Pfann LC OC LA OA MV	
Back	_____	
Extremities	_____	
Neuro	_____	
Derm	_____	
Pelvic	_____	

Preventative Medicine

Breast exam	<input type="checkbox"/>
Pap test	<input type="checkbox"/>
Smoking/Diet/Exercise	<input type="checkbox"/>
Calcium Supplementation	<input type="checkbox"/>

EP	Level 2	Level 4	EM Bx	IUD	Pelvic U/S
NP	Level 3		Colpo Bx	ECC	Mammo Screen/Diag.
Consult	Annual exam				Breast U/S