Women's Health of Oregon

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NEW PATIENT CONFIDENTIAL MEDICAL HISTORY

Name:_____ DOB:_____ Age:_____ Today's Date:_____

Preferred name:_____

Primary Care Doctor (this is NOT a primary care office) : _____

What is the reason for your visit today?

_____

PAST MEDICAL HISTORY

Please check any **diagnosed** *medical conditions or problems. (If there are none, please* ***MARK*** *none)*

() ***NONE***
() Anemia
() Asthma or Lung Problems
() Bladder Problems
() Blood Clotting Disorder
() Cancer (Type:_____)
() Depression
() Diabetes (Type:_____)
() Eating Disorder
() Eye Problem
() Fracture (if within the last 5 years)
() Gall Bladder or Liver Problem
() Other:_____
() High Blood Pressure
() High Cholesterol
() Kidney Problems
() Major Infections (TB, Hepatitis, HIV, etc.)
() Migraines/Severe Headaches
() Osteoporosis
() Other Psychiatric Problem
() Seizures
() Stomach or Bowel Problem
() Stroke
() Thyroid disorder
() Heart Disease

SCREENING STUDIES YOU HAVE HAD

Please indicate **DATES (even if it is not exact)** *to the best of your ability.*

Pap Smear_____
*Abnormal Pap Smear*_____
Bone Density Scan_____
Cholesterol Panel_____
Mammogram_____
Colonoscopy_____
Blood Sugar Level_____
Eye Exam_____

PAST SURGICAL HISTORY (any surgeries you think the doctor should know about)

() ***NONE***

Surgery or procedure	**Date**	**Performed by**	**Reason**

ALLERGIES

() ***NO KNOWN DRUG ALLERGIES*** (please check circle if NO allergies)

Medication Name	Reaction	When Diagnosed
_____	_____	_____
_____	_____	_____

MEDICATIONS/SUPPLEMENTS (VITAMINS) If you do not take any please **MARK NONE.**

() ***NONE***

Medication Name and Dose	Instructions	Prescribed by
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY MEDICAL HISTORY

Please indicate which family member and which side of your family (maternal or paternal)

Anesthetic Reactions_____
Breast Cancer_____
Colon Cancer_____
Diabetes I or II_____
Heart Disease_____
Inherited Diseases_____

Osteoporosis_____
Ovarian Cancer_____
Thyroid Problems_____
Uterine Cancer_____
Cervical Cancer_____

Other_____

GYNECOLOGIC HISTORY

Last Menstrual Period (first day) _____
Periods occur every _____ days. (example: 28, 30, 35)
Periods last _____ days.
Average Flow () Light () Medium () Heavy

How much do you cramp (scale 1-10)? _____

Current Birth Control Method _____ (pills, condoms, vasectomy, etc.)

Do you desire to change your birth control method at this time? _____

Infection History (provide *dates*)

() Chlamydia _____ () Herpes_____ () HPV_____

() Gonorrhea _____ () Other_____

*Have you received the HPV vaccines? () NO () YES How many injections? (1-3) _____

Obstetric History

Total Pregnancies_____ Live Births_____ Miscarriages_____ Abortions_____

Complications with any of the above? _____

SOCIAL HISTORY

() Single () Married () Partnered () Divorced () Separated () Widowed

Sexually Active with: () Males () Females () Both () Virginal

Number of sexual partners in the last 1 year_____ 3 years_____

Do you feel safe in your current relationship? _____

Your Occupation: _____

Your Education Level: _____

Alcohol: () NONE _____ drinks per week

Caffeine:() NONE _____ cups per day

Tobacco: () Current _____ cigarettes per day _____age started
() Former _____ age quit () ***NEVER***

Recreational Drug Use: () NONE I use_____ how often_____

Exercise: () ***NONE***
() Active but no formal exercise
() One to three times a week
() Once weekly or less
() Four or more times weekly

ARE YOU *CURRENTLY* EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?
Mark the circle if the answer is *yes.*

constitutional

() fever
() chills
() sweats
() weight change – gain or loss
() weakness
() fatigue

eyes

() change in vision

ears, nose, mouth, throat

() change in hearing
() nose bleeds
() sore throat
() dry mouth

cardiovascular

() dizziness
() shortness of breath
() chest pain
() loss of consciousness
() palpitations

respiratory

() cough – productive or dry
() wheezing

gastrointestinal

() abdominal pain
() nausea, vomiting
() change in bowel habits
() change in appetite
() dark or bloody stool
() indigestion
() constipation or diarrhea
() bloating for more than 30 days

hematologic / lymphatic

() swollen lymph glands

() bruise easily

gynecological

() bleeding or pain with intercourse
() unusual vaginal discharge or odor
() vulvar or vaginal itching or burning
() pelvic pain
() bleeding after menopause

musculoskeletal

() back pain
() weakness
() joint pain, stiffness, swelling

urinary

() painful
() frequent
() urgency

() blood in urine
() urinary incontinence
() getting up at night to urinate

integumentary / breast

() nodules

() change in moles, freckles
() change in hair – growth, loss, texture

() lumps
() nipple discharge

() breast pain

neurological / psychiatric

() numbness or tingling
() memory change
() depression
() anxiety
() mood swings

endocrine

() tremor

() excessive thirst
() sleep disturbances
() cold or heat intolerance

() night sweats () hot flashes

() NO CURRENT SYMPTOMS

Thank you for carefully filling this out,
we appreciate you.