WOMEN'S HEATH ADVANTAGE **PATIENT HEALTH HISTORY**

Patient Name: ______________________ **Age:** __________ **Date of Birth:** __________

Family Doctor: ______________________ **Referred By:** ______________________

Reason for Visit: ____

Past Medical History

CONDITION	CURRENT	HISTORY	NO	CONDITION	CURRENT	HISTORY	NO
Abnormal PAP Smear				Herpes			
Anemia				Human Immunodeficiency Virus (HIV)			
Anesthesia Complication				Human Papilloma Virus (HPV)			
Anxiety				Hypertension			
Asthma				Infertility			
Blood Clot in Legs or Lung				Kidney Stone			
Blood Transfusion				Liver Disease			
Breast Disorder				Lupus			
Cancer of the Breast				Migraine			
Cancer, other				Mitral Valve Prolapse			
Cardiovascular Disease				Pelvic Inflammatory Disease			
Chlamydia				Rheumatic Fever			
Depression				Seizures/ Convulsions			
Diabetes				Stroke			
Endometriosis				Syphilis			
Epilepsy				Thyroid Disorder			
Fibromyalgia				Trichomoniasis			
Gonorrhea				Tuberculosis			
Heart Murmur				Ulcer			
Hepatitis B				Urinary Tract Infection			
Hepatitis C							

Date of Last Pap Smear: / / Normal Abnormal Date of Last Mammogram: / / Normal Abnormal

Date of Last Dexa Scan: / / Normal Abnormal Date of Last Colonoscopy: / / Normal Abnormal

Other:

OPERATIONS/SURGERIES

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
1)		4)	
2)		5)	
3)		6)	

MEDICATIONS

(Include prescriptions, over the counter, herbals & vitamins)

MEDICATION	DOSAGE	PRESCRIBING PHYSICIAN
1)		
2)		
3)		
4)		
5)		
6)		

MEDICATIONS / ALLERGIES

MEDICATION	REACTION
1)	
2)	
3)	

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FAMILY MEDICAL HISTORY

(Do any of your children, siblings, or parents have any of the following?)

ILLNESS	YES	RELATIONSHIP	ILLNESS	YES	RELATIONSHIP
NONE			Cardiovascular Disease		
ADOPTED			Depression		
Blood Clot in Legs or Lungs			Diabetes		
Cancer, Breast			Hypertension		
Cancer, Colon			Osteoporosis		
Cancer, Ovarian			Polyp - anal/rectal/colon		
Cancer, Uterine			Stroke		
Cancer, Other			Thyroid Disorder		

GENETIC HISTORY / SCREENING

(Self, partner, or other family member)

CONDITION	YES	RELATIONSHIP	CONDITION	YES	RELATIONSHIP
Cats - do you have exposure?			Ingestion of uncooked meat		
Chickenpox			Patient age > 35 years as of EDC		
Congenital Heart Defect			Phenylketonuria (PKU)		
Cystic Fibrosis			Rh Sensitized		
DES Exposure			Sickle Cell Anemia		
Diabetes - self only			Tay-Sachs Disease		
Down Syndrome			Thalassemia (Italian, Greek, Mediterranean)		
Infertility			Uterine Defect		

REPRODUCTIVE HISTORY

Age of first menses:	Cycle Interval (# of days from start of period to start of next period):
Menses duration (number of days of bleeding):	Flow (circle): Light Medium Heavy
Number of Tampons/day:	Number of Pads/day:
Last Menstrual Period: / / (Date)	Certain of LMP Date? (circle): YES NO
Menopause Status (circle): Pre Peri Post	Age at Menopause:
Method of Birth Control	Clots (circle): YES NO
Breakthrough Bleeding (circle): YES NO	On HRT (circle): YES NO

PREGNANCY HISTORY

DATE	GESTATIONAL AGE	HOURS IN LABOR	BIRTH WEIGHT	SEX	TYPE OF DELIVERY	ANESTHESIA	EARLY LABOR?	COMMENTS/COMPLICATIONS	HOSPITAL

SOCIAL HISTORY

Marital Status (circle): Divorced Married Single Widowed Spouse/Partner Name:
Occupation
Alcohol: ___Never ___Current ___Former ___Amount Per Week
Drugs: ___Never ___Current ___Former ___Type
Smoking: ___Never ___Current ___Former ___Amount Per Week
Amount of Exercise (circle): Active Heavy Medium Minimal None (Sedentary)

WHA 129b