Total Woman Health Care, P.A.
Health History Form

PATIENT INFORMATION:

Patient Name: _____ Today's Date: _____

Age: _____Date of Birth: _____

Chief Complaint/What are you here for? _____

_____

Preferred Pharmacy: _____

MENSTRUAL HISTORY:

1st Day of Last Menstrual period: _____Age of First Period: _____

Are your periods regular? _____Cycles 28 days? _____ Less? _____ More? _____

Is the flow normal? _____ Light? _____ Moderate? _____ Heavy? _____Do you spot between periods? _____

Are your periods painful? _____ Last PAP? _____ Last Mammogram? _____

OBSTETRIC HISTORY:

Number of Times Pregnant? _____ Date of Last delivery? _____ Number of Living Children? _____

Number of Miscarriages? _____ Number of Medical Abortions? _____

CONTRACEPTIVES: (Used in the past and current method)

BC Pills _____ IUD _____ Tubal Ligation_____ Vasectomy _____ Depo _____ Nexplanon _____ Patch _____

Condoms _____ Abstinent _____ Other: _____

MEDICAL HISTORY: (Please circle if these medical conditions apply to you)

High Blood Pressure	Anemia	Other: _____
Cancer	Epilepsy	
Asthma	Stroke	Any Surgeries? _____
Heart Disease	Diabetes	_____
Kidney Disease	Blood Clots	_____

Do you smoke? Yes No

Any Street Drugs? Yes No

Allergies? _____

_____

_____

FAMILY HISTORY: (Please circle all that apply)

Medications: _____

_____

_____

_____

_____

_____

	Fa	Mo	GP
Sickle Cell	____	____	____
Diabetes	____	____	____
High BP	____	____	____
Heart Disease	____	____	____
Cancer	____	____	____
Kidney Disease	____	____	____
Stroke	____	____	____
Asthma	____	____	____