

AZALEA CITY PHYSICIANS FOR WOMEN, P.C.

Patient Name: _____ Date of Birth: _____

MENSTRUAL HISTORY:

Date of Last Period: _____ Period Regularity: Regular Irregular

Duration of Period (# of days): _____ Menopausal: Yes No Hysterectomy: Yes No

Cramps: Yes No Severity of Cramps: Mild Moderate Severe

Birth Control Method: Pills Condoms IUD Depo-Provera Other _____

OBSTERICAL HISTORY:

Total # of Pregnancies: _____ # Living: _____ # Abortions: _____ # Miscarriages: _____

Date	Type of Delivery	Weight	Sex	Complications
	<input type="checkbox"/> Vag <input type="checkbox"/> C-section		<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> Vag <input type="checkbox"/> C-section		<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> Vag <input type="checkbox"/> C-section		<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> Vag <input type="checkbox"/> C-section		<input type="checkbox"/> M <input type="checkbox"/> F	

SURGICAL HISTORY:

- Appendectomy Cesarean Section Essure Laparoscopy
- Breast Biopsy Cholecystectomy Hysterectomy Novasure
- Breast Implants Breast Reduction Hysteroscopy Cryosurgery
- Mastectomy D&C LEEP Tubal Ligation
- Other _____

MEDICAL HISTORY: (PLACE A CHECK UNDER "Y" FOR YOURSELF AND/OR "F" FOR FAMILY HISTORY IF APPLIES)

Description	Y	F	Description	Y	F	Description	Y	F
Heart Disease			Diabetes			Mental/Emotional		
High Blood Press.			Thyroid			Phlebitis/Blood Clots		
Pulmonary Dis.			Herpes			Seizures		
Breast Problems			Syphilis			Congenital Abnormalities		
Hepatitis			Gonorrhea/Chlamydia			Breast Cancer		
Kidney Disease			Venereal Warts			Ovarian Cancer		
Sickle Cell Dis.			HIV			Migraines		
Uterine Fibroids			Blood Anemia/Transf.			Uterine Cancer		
Leaking Urine			Abnormal Pap					

Other Medical History: _____

Allergies: _____

SOCIAL HISTORY: Married Single **Exercise:** Yes No

Smoke: Yes No # of cigarettes per day ____ **Alcohol:** Yes No # of drinks per week ____

Illegal Drugs: Yes No **Caffeine:** Tea/Coffee ____ cups per day Colas ____ cans per day

Sexual History: Satisfactory Uncomfortable Wish to Discuss with Physician

PREVENTATIVE (HAVE YOU EVER HAD THE FOLLOWING?): Pap Smear

Mammogram Bone Density Test Thyroid Screen Gardasil Vaccine Hepatitis A/B Vaccine

CURRENT MEDICATIONS: (PRESCRIPTION & OVER THE COUNTER MEDS) _____

Patient Signature: _____ Date: _____