Northwest Women's Consultants

Medical History Form

DATE__________ **NAME**____**DATE OF BIRTH**____________________

OCCUPATION________________________________**Primary Care Physician**____

WHO REFERRED YOU __________________________________

Which pharmacy do you want to use?

❑ **Pharmacy**__________________________ _____________________ ❑ **Mail Order Pharmacy**_________________________

Name Phone Name

The following information will assist in providing your care. This information is kept confidential.

Please fill out both sides of this form completely.

Have you ever had the following (circle all that apply)

Abnormal Mammo
Abnormal Pap
Anemia
Arthritis
Asthma/Emphysema
Blood Transfusion
Cancer-type
Clotting Disorder
Depression
Diabetes (Type I or II)
DVT/PE
Endometriosis
Epilepsy
Fibroids-Uterus
Frequent Bladder Infections
Genetic Disorder
GERD
Headaches/Migraines
Heart Disease
High Cholesterol
High Blood Pressure
HIV/AIDS
Irregular Vaginal Bleeding
Irritable Bowel/Colon
Kidney Disease
Liver Disorder
Lupus
Mitral Valve Prolapse
Osteopenia
Osteoporosis
Painful Periods
Problem with Anesthesia
STD-History of
Stroke
Thyroid-Low (Hypothyroid)
Thyroid-High (Hyperthyroid)
Vaginal Infections
Other:

Your most recent	Date	Result	Your most recent	Date	Result
Pap Smear			Colonoscopy		
HPV test			Cholesterol Check		
Mammogram			Bone Density Scan		

List all Surgeries and Procedures

Surgery/Procedure	Year Performed	Surgery/Procedure	Year Performed

List all prescription and over the counter medication and supplements you take regularly

Medication	Dose	Frequency (how often)	Prescribing physician (or over the counter)

List all allergies to medication and the reaction you have if you take them

Allergic to:	Reaction	Allergic to:	Reaction

FAMILY HISTORY: Are you Adopted? NO Yes-if blood relative history unknown, proceed to page 2

Has any blood relative had any of the following? Indicate "M" for maternal, "P" for paternal (i.e. if your Mother's mother, write MGM)

Problem	Family Member	Age onset	Problem	Family Member	Age Onset
Cancer-Breast			DVT/PE		
Cancer-Colon			Heart Disease		
Cancer-Ovarian			High Cholesterol		
Cancer-Uterine			Hypertension		
Diabetes, type I			Thyroid Disorder		
Diabetes, type II			Osteoporosis		