Mid-Kansas Women's Center, PA
Patient History Form

Date: _____ Legal Name: _____Preferred Name: _____

Date of Birth: _____

Primary Care Physician: _____ Referring Physician: _____

Reason for Visit: _____ Pharmacy: _____

Personal History

Abnormal Pap Smears
Anemia
Arthritis
Asthma
Blood Clot
Blood Transfusion
Breast Lump
Cancer:
- Breast
- Cervical
- Colon
- Ovarian
- Skin
- Uterine

Chronic Pelvic Pain
Chronic Urinary Infection
Chronic Vaginal Infection
Colonic & Rectal Disorders
Crohn's Disease
Diabetes
Elevated Cholesterol
Endometriosis
Endometrial Hyperplasia
Fibrocystic Breast
Fibromyalgia
Habitual Aborter (>3 Miscarriages)
Heartburn/Reflux
Heart Disease:
- Angina
- Congestive heart failure
- Coronary artery disease

MVP
Heavy Bleeding
Hepatitis (type: _A, _B, _C)
Hiatal Hernia
High Blood Pressure
HIV/Aids
IBS
Infertility
Irregular Periods
Kidney Stones
Migraines
Osteopenia/Osteoporosis
Ovarian Cyst
Pelvic Inflammatory Disease
Seizure Disorder
Psychiatric Disorder:
- Bipolar Disorder
- Depression
- Obsessive/Compulsive
- Schizophrenia

Sexually Transmitted Disease:
- Chlamydia
- Genital Warts
- Gonorrhea
- Herpes
- Trichomonas

Stroke
Thyroid Disorder:
- Goiter
- Graves
- Hyperthyroid
- Hypothyroid

Urinary Loss of Control
Uterine Fibroids
Varicose Veins
Other: _____

Surgeries/Procedures

Age or Yr.	
_____	Adenoids
_____	Appendectomy/Appendix
_____	Breast Augmentation
_____	Breast Reduction
_____	Cataracts
_____	Cardiac Surgery (_____)
_____	Cesarean Section
_____	Cervical Procedures:
_____	Colposcopy
_____	Cone Biopsy
_____	Cryo
_____	Laser
_____	Leep
_____	Cystoscopy
_____	Other: _____

Age or Yr.	
_____	D & C
_____	Endometrial Ablation
_____	Gallbladder Removed
_____	Hip Replacement R or L
_____	Hysteroscopy
_____	Hysterectomy (Abd / Vag / Laparoscopic / Robotic)
_____	Knee Replacement R or L
_____	Laparoscopy
_____	Laparotomy
_____	Mastectomy R / L / B
_____	Ovaries Removed R / L / B
_____	Tonsillectomy
_____	Tubal Ligation
_____	Wisdom Tooth Extraction

Obstetrical History

Please fill out for each pregnancy even if it was a miscarriage or abortion.

If you've had a tubal ligation, hysterectomy, or are over the age of 50, only date and type of delivery are necessary.

Preg #	*Type*	*Date mm/yy*	*Gestational Age*	*Wt.*	*Sex*	*Hospital*	*Doctor*	*Complications*
	Abortion C-Section Miscarriage Vaginal Delivery		*Term / Preterm*		*M / F*			
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	Abortion C-Section Miscarriage Vaginal Delivery		*Term / Preterm*		*M / F*			
	Abortion C-Section Miscarriage Vaginal Delivery		*Term / Preterm*		*M / F*			
	Abortion C-Section Miscarriage Vaginal Delivery		*Term / Preterm*		*M / F*			

Family Medical History

Please check if anyone in your immediate family has been diagnosed or treated for the following:

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Arthritis								
Blood Clot								
Breast Cancer								
Cervical Cancer								
Colon Cancer								
Ovarian Cancer								
Skin Cancer								
Uterine Cancer								
Other Cancer ________								
Diabetes								
Heart Disease								
Hepatitis								
High Cholesterol								
Hypertension								
Kidney Disease								
Osteoporosis								
Pulmonary Disease								
Stroke								
Thyroid Disorder								

Social History

Marital Status: Married Divorced Legally Separated Single Widowed Dating

Exercise: 2-3x/week 3-4x/week Daily Never Occasional Rarely

Tobacco Use: No Yes Former

Type: _____ Amt/day: _____ # Years: _____ Year Quit: _____

Alcohol Use: No Yes Former

Frequency: _____ Year Quit: _____

Illicit Drug Use: No Yes Former

Type: _____ #Years: _____ Year Quit: _____

Sexual Preference: Heterosexual (Straight) Homosexual (Gay) Bisexual

Current Gender Identity: Male Transgender Male Female Transgender Female Non-Binary

History of Physical Abuse? Yes or No **History of Sexual Abuse?** Yes or No

Menstrual History

Age at First Period: _____ First Day of Last Period: _____
How many days do you flow? _____ Length of time between periods: _____
Do you have cramping? Yes or No Bleeding between periods? Yes or No
Do you use more than 2 pads per hour? Yes or No Bleeding after intercourse? Yes or No
What type of birth control/method are you using? _____

Health Maintenance

Date of last Pap Smear: _____ Result: Normal Abnormal

Date of last Mammogram: _____ Result: Normal Abnormal
Breast Biopsy: Yes or No Result: _____

Date of last Bone Density: _____ Result: Normal Abnormal

Date of last Colonoscopy: _____ Result: Normal Abnormal

Vaccine History

Hepatitis A:	Yes or No	Hepatitis B:	Yes or No
Zostavax (Shingles):	Yes or No	Gardasil (HPV):	Yes or No
Tetanus (within last 5 years):	Yes or No	Varicella (Chicken Pox):	Yes or No
Pneumovax (Pneumonia)	Yes or No		

Medications

Please include all over the counter medications and prescription medications.

Medication	Dose/Strength	# of pills/amt	Times/day

Medication ***allergies*** and ***reaction***:

Medication	Allergies/Reaction