Allentown Women's Center

Medical History

Legal Name: ____ DOB: _______________

Preferred Name: __________________________ Pronouns: _____________________________

Date of Visit: ______________

Allergies- list medication and reaction:

(Please include all foods, drugs, and medical supplies)

Medications – list dosage and frequency:

Medical History:

No	Yes	Now	Condition	Staff Notes
			Diabetes (sugar in blood/urine)	
			High Blood Pressure	
			High Cholesterol	
			Leg Pain/Varicose Veins	
			Severe Headaches or Migraines	
			Liver Problems (hepatitis, jaundice, mono)	
			Epilepsy/Seizures	
			Thyroid Problems	
			Asthma/Breathing Problems	
			Depression/Anxiety	
			Gall Bladder Problems	
			Cancer (specify type):	
			Severe Acne	
			Bleeding Problems	
			Heart Problems	
			Dizziness or Fainting	
			Bladder/Kidney Problems or Infections	
			Breast Problems or Breast Disease	
			Autoimmune Disorder	
			Excessive Hair Growth	
			Fluid retention/Bloating	
			Other conditions (list):	

Do you smoke cigarettes? ❑ No ❑ Yes –number of cigarettes per day: _________

Have you been tested for HIV? ❑ No ❑ Yes - date of last test: _______________

If yes, status: ❑ Negative (-) ❑ Positive (+) ❑ Unsure

Do you feel safe in your relationships with your family members and intimate partner(s)? ❑ No ❑ Yes

Do you feel controlled or isolated by your partner(s)? ❑ No ❑ Yes

Are you in a relationship where you are ever hurt, threatened, or made to feel afraid? ❑ No ❑ Yes

Please continue onto the back ➔ ➔ ➔

Surgical History: ❑ I have never had surgery

Surgery	Surgery Date

Family History: ❑ Adopted or family history unknown

Yes	No	Condition	Family Member(s)
		Diabetes	
		Heart Attack (before age 50)	
		Heart Disease	
		High Blood Pressure	
		Stroke	
		Cancer (specify type):	
		Breast disease	

Mother: ❑ Alive ❑ Deceased – cause: ____

Father: ❑ Alive ❑ Deceased – cause: ____

Menstrual & Pregnancy History (if applicable)

Menstrual History:

Age at first period: __________ Average number of days your bleeding lasts: __________

Average number of pads/tampons used per day: __________

First day of your last (or current) period: ____________________

Pregnancy History: ❑ I have never been pregnant

Age at first pregnancy: __________

Total number of pregnancies: __________ Number of living children: __________

Date Ended		Birthweight	
	❑ vaginal delivery ❑ c-section		❑ miscarriage ❑ abortion ❑ stillbirth
	❑ vaginal delivery ❑ c-section		❑ miscarriage ❑ abortion ❑ stillbirth
	❑ vaginal delivery ❑ c-section		❑ miscarriage ❑ abortion ❑ stillbirth
	❑ vaginal delivery ❑ c-section		❑ miscarriage ❑ abortion ❑ stillbirth
	❑ vaginal delivery ❑ c-section		❑ miscarriage ❑ abortion ❑ stillbirth
	❑ vaginal delivery ❑ c-section		❑ miscarriage ❑ abortion ❑ stillbirth

List any complications: ____

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Patient Signature: ____ **Date:** ____________________

Clinician Signature: ______________________________________ **Date:** ____________________