MID-KANSAS WOMEN'S CENTER, PA
PATIENT HISTORY FORM

We are currently implementing electronic medical records. Please assist us by providing an updated, accurate medical history.

Date_____

Patient Name_____ Date of Birth_____

Primary Care or Referring Physician_____

Provider (circle one): Agustin Bates DeHart Evans-DeBeverly Lopez Rogers

Reason for Visit_____

Preferred Pharmacy_____ Location_____

Currently Experiencing: (Please circle all that apply)

General:	Recent Weight Loss / Recent Weight Gain/ Fever / Sweating at night / Fatigue / Fainting
Eyes:	Seeing Double / Eye Pain / Wearing Glasses / Currently Wearing Contacts
Cardiovascular:	Chest Pain or Discomfort / Difficulty Breathing During Exertion / Hypertension / Varicose Vein
Respiratory:	Cough / Coughing up Blood / Wheezing
Gastrointestinal:	Heartburn / Abdominal Pain / Constipation / Diarrhea / Hemorrhoids / Pelvic Pain / Blood in Stools / Black Stools
Breast:	Nipple Discharge / Breast Lump / Breast Pain
Skin:	Rash / Increased Hair Growth / Hair Loss (Head/Body)
Urinary:	Kidney Infections / UTI / Kidney Stones / Burning during urination / Urinary Loss of Control / Vaginal Discharge / Vaginal Itching/Burning / Pain with Intercourse
Psychiatric:	Emotional Concerns / Anxiety / Depression / Previous Psychiatric Treatment
Endocrine:	Excessive Thirst / Heat Intolerance / Cold Intolerance / Premenstrual Mood Changes / Hormones
Neurologic:	Convulsions / Headache / Tremors
Hematologic:	Anemia / History of Transfusions / Easy bruising / Nose Bleeds

Personal History

(Circle Yes or No)

	Yes/No	Additional Notes:
Headache	Y or N	
Heart Disease	Y or N	
HIV/Aids	Y or N	
Hypertension	Y or N	
High Cholesterol	Y or N	
Asthma	Y or N	
Pulmonary Disease	Y or N	
Stroke	Y or N	
Breast Disorders	Y or N	
Jaundice	Y or N	
Hepatitis A	Y or N	
Hepatitis B	Y or N	
Hepatitis C	Y or N	
Hiatal Hernia	Y or N	
Peptic Ulcer	Y or N	
Colonic and Rectal Disorders	Y or N	
Renal Disease	Y or N	
Urinary Loss of Control	Y or N	
Urinary Tract Infection	Y or N	
Blood Transfusion	Y or N	
Anemia	Y or N	
Varicose Veins	Y or N	
Blood Clot	Y or N	
Diabetes	Y or N	
Thyroid Disorders	Y or N	
Skin Cancer	Y or N	
Breast Cancer	Y or N	
Uterine Cancer	Y or N	
Ovarian Cancer	Y or N	
Colon Cancer	Y or N	
Seizure Disorder	Y or N	
Arthritis	Y or N	
Depression	Y or N	
Sleep Disorders	Y or N	
Osteoporosis	Y or N	
Recurrent Miscarriage	Y or N	

Additional Medical History:

Menstrual History: (Please Circle Y= Yes and N= No)

1. Age at First Period: _____
2. First Day of Last Period: _____
3. Do you have Monthly Periods? Y or N
4. Do you flow > 5 days? Y or N
5. Menstrual Cramping? Y or N
   If Yes, Pain Level (1-10) _____
6. Normal Menstrual Frequency? Y or N
   If No, How Often? _____
7. Bleeding Between Periods? Y or N
8. Bleeding After Intercourse? Y or N
9. Is your flow Light Average or Heavy? (circle one)

Vaginal Infections: (Please Circle Y= Yes and N= No)

1. Yeast Infections Y or N
2. Trichomoniasis (Trich) Y or N
3. Chlamydia Y or N
4. Herpes Y or N
5. Gonorrhea Y or N

Prior Paps:

1. Date of last Pap: _____
2. History of Abnormal Paps? Y or N
3. History of Treatment to Cervix Y or N

Mammogram: (Please Indicate When)

1. Last Mammogram: _____
2. Breast Biopsy _____

Osteoporosis Test:

1. Osteoporosis Test: Normal or Abnormal Date:_____

Contraceptive History:

1. Current Birth Control Method: _____
2. Hormonal Contraceptives: _____
3. IUD: _____
4. Vasectomy or Tubal Ligation: _____

Menopausal History: (Please Circle Y= Yes and N= No)

1. Menopause has occurred: Y or N
2. Hot Flashes: Y or N
3. Age of onset _____

Pregnancies/Birth History/Abortions/Terminations:

Date	Gestational Age (Wks)	Length of Labor	Baby Weight (lbs/oz)	Sex (M/F)	Delivery Type Vaginal / C-Section	Place	Complications

Surgeries/Procedures

(procedures include bladder studies, colposcopy, colonoscopy, endometrial biopsies, etc.)

Type	When (Date or Year)	Location

Family History

(Circle Y or N if there is a Family History and mark box with an X for Family Member)

Diagnosis	Family History	Brother	Sister	Mother	Father	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother
Breast Cancer	Y or N								
Uterine Cancer	Y or N								
Ovarian Cancer	Y or N								
Colon Cancer	Y or N								
Skin Cancer	Y or N								
Cancer	Y or N								
Diabetes	Y or N								
Osteoporosis	Y or N								
Heart Disease	Y or N								
High Cholesterol	Y or N								
Hypertension	Y or N								
Pulmonary Disease	Y or N								
Hepatitis	Y or N								
Kidney Disease	Y or N								
Thyroid Disorder	Y or N								
Arthritis	Y or N								
Blood Clot	Y or N								
Stroke	Y or N								

Additional Family History:

Social History:

1. Smoking Y or N
   a. Current Smoker # of Years ____ #Packs Per Day ____
   b. Past Smoker # of Years ____ #Packs Per Day ____
   Date of Last Use _____
2. Alcohol Consumption Y or N # Drinks per Day: _____
3. Daily Coffee Consumption: Y or N # Cups Per Day: _____
4. Drug Use: Y or N
5. Exercise Habits: Y or N Type: _____
6. Sexual Preference Male Female Both
7. History of Physical Abuse? Y or N
8. History of Sexual Abuse? Y or N
9. Marital Status Married Single Divorced

Vaccine History: (Please Circle Y= Yes and N= No)

1. Hepatitis A: Y or N
2. Hepatitis B: Y or N
3. Gardisil (HPV) Y or N
4. Tetanus (within last 5 years) Y or N

Current Medications	
Medication Name	**Dosage/Frequency**

Drug Allergies	
Type:	**Reaction:**