Patient History Form **West County Women's Healthcare, LLC**

Note: this is a confidential record and will be kept in your doctor's office. Information contained on this form will not be released without your permission.

Who are you seeing today? *(Please circle one)* McDonald Murphy Wallace, NP

Name:_____Date:_____ Date of Birth:__/__/__ Age:___

Phone number: _____

How did you hear about our practice: _____

PCP Name: _____ Pharmacy Name & Phone Number: _____ Pharmacy Phone

Chief Complaint/History of Present Illness

What is the reason for your visit? (Be as specific as possible)

_____

_____

_____

Medication and Allergies

Are you on any medications? Y N (If yes, list all)	Do you have any allergies? Y N (If yes, list all)
_____ _____	_____ _____
_____ _____	_____ _____
_____ _____	_____ _____
_____ _____	

Past Medical History

Have you ever had any of the following? (Please circle all that apply)

Anemia	Seizures	Asthma	High Cholesterol
Heart Disease	Gall Bladder Disease	Migraines	Pneumonia
High Blood Pressure	Blood transfusion	Liver disease	Diabetes
Rheumatic Fever	Pelvic Infection	Depression/Anxiety	Sickle Cell Trait
Mitral Valve Prolapse	Bladder Infections	Drug or Alcohol Problems	Blood clot in leg/lung
Thyroid problem	Genital Herpes	Gonorrhea/Syphilis/Chlamydia	Osteopenia
Stroke	Tuberculosis	Kidney Stones/Infections	Bleeding Disorder
Emphysema/COPD	MRSA	Hepatitis B	Hepatitis C
Sleep Apnea	Breast Disease	Stomach/Bowel problems	
Glaucoma	Osteoporosis	Cancer Type:_____	
Other (please list details):			

Surgical History

Surgical History and dates			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Health Maintenance

Date of last mammogram: _____ Date of last Bone Density: _____

Date of last colonoscopy: _____

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Family History

Has any relative ever had: **Please list who** (mom, dad, sibling, Maternal Grandparent etc.) **and Age**

Breast Cancer_____ High Blood Pressure_____ Osteoporosis_____

Colon Cancer_____ Diabetes_____ Heart Disease_____

Ovarian Cancer _____ Stroke_____ Tuberculosis_____

Uterine Cancer_____ Sickle Cell Disease_____ Bleeding Problems _____

Prostate Cancer _____ Thyroid Disease_____

Pancreatic Cancer _____

Other_____

_____

Have you completed genetic testing? Yes or No

Social History

Do you smoke? Y N How much? _____ For how long? _____

Do you drink alcohol? Y N How much? _____ For how long?_____

Do you use any street drugs? Y N If yes, please list_____

Marital Status: _____Single _____Married _____Separated _____Divorced _____Widowed

Sexual Orientation: _____Heterosexual _____Lesbian _____ Bisexual _____ Transgender _____

Occupation: _____ Religion: _____

Past Obstetrical History

Please list all pregnancies in order (including miscarriages, premature births, abortions, etc.)

DOB	Sex	Weight	Type of Delivery	Weeks Pregnant	Anesthetic	Complications

Past Gynecologic History

Are you sexually active? Y N

Have you been diagnosed with a sexually transmitted disease? Y N

If yes, please select below:

_____Gonorrhea _____Chlamydia _____Genital Warts _____HPV _____Herpes

_____Syphilis _____HIV

Have you received the Gardasil vaccine? Y N Have you completed the vaccine series? Y N

Indicate any problems you have had either in the past or currently:

_____ Vaginal Infections _____IUD Related problems _____Pelvic Inflammatory Disease (PID)

Date of beginning of last menstrual period _____ Are you menopausal Y N – HRT: _____

Method of birth control (pill, patch, ring, implant, IUD, natural family planning, condoms, abstinence) _____

Age of first period _____ Are your periods regular? Y N

Cycle every ___ days Cycle lasts _____days Flow: Light Moderate Heavy Pain or cramping? Y N

Date of last pap smear _____ Past abnormal pap smear? Y N

Have you had treatment from an abnormal pap smear? (please list what and when) _____

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Review of Systems

Do you have any of the following problems? If so, please circle

General
Weight Changes >10 lbs
Fever
Fatigue
Headache

Skin
Rash/Sores
Mole Changes

Head and Neck
Visual Changes (not glasses)
Blurred Vision
Double Vision
Trouble Hearing
Sinus Problems
Sore Throat

Musculoskeletal
Joint Pain
Muscle Weakness
Muscle Pain

Respiratory/Lungs
Shortness of Breath
Wheezing
Cough
Sleep Apnea

Neuro
Numbness or tingling
Dizziness
Seizures

Cardiovascular
Chest Pain
Difficulty Breathing
Irregular rapid heartbeat
Swelling

Endocrine
Changes in hair/hair loss
Heat/Cold Intolerance
Frequent sweats/hot flashes
Excessive Thirst

Gastrointestinal
Nausea/Vomiting
Frequent heart burn/acid
Abdominal pain
Diarrhea (Frequent)
Constipation

Psych/Social
High anxiety/stress
Martial/relationship problems
Depressed mood/crying
Thoughts of Suicide
Forgetfulness/Confusion

Allergic/Immunologic
Hay Fever
Seasonal Allergies
Medications

Hematologic/Lymphatic
Swollen glands
Bruise/Bleed easily

Breast
Nipple Discharge
Lumps
Skin Changes

Genitourinary/Women
Pelvic Pain
Urine Leakage
Vaginal discharge
Abnormal bleeding
Menopause
Painful Periods
Decreased sexual desire
Frequent Urination
Burning with Urination
Vaginal dryness
Menstrual problems
Infertility
Painful intercourse

PLEASE CHECK ☐ IF NONE