All * Women's

HEALTHCARE OF WEST BROWARD

Patients Name:____**DOB:**___________________

Primary Care Physician:_________________________________ **Phone #**_________________________

Pharmacy:____________________**City:**__________________ **Number:**______________________

1. **Medications:** List any medications and dosage, including vitamins and over the counter medications, that you are presently taking.

Name of medication	Dosage/Strength	How often you take it	Oral/Injection/Topical
			Oral / Injection / Topical
			Oral / Injection / Topical
			Oral / Injection / Topical
			Oral / Injection / Topical
			Oral / Injection / Topical
			Oral / Injection / Topical

2. **Medical History i.e.** Headaches, high blood pressure, diabetes's

3. **Allergies to medication:** **Allergic to any medicine** Yes No

(Please Circle) Peanuts Shellfish Latex Adhesive Tape Betadine Metal Nickel

Name of Medication	Reaction (rash, itching, shortness of breath, nausea)

4. **List all of your gynecological problems:**_____________________________________

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Method of Birth Control:_____________________________Sexually active: **YES or NO**

Last menstrual period _______________How often-(days)________Blood Flow:___________

Ever had any abnormal pap's **NO / YES** **Procedures**_____________________________

Last pap smear:_________________________ **Normal / Abnormal** ___________________

Last mammogram:________________________**Normal / Abnormal** ___________________

Last Bone Density:_______________________**Normal / Abnormal** ___________________

Last Colonoscopy:_______________________ **Normal / Abnormal** ___________________

5. Pregnancy and Birth: # Pregnancies _____# Living Children_____ # Still births_____

#Vaginal _____ #C-Sections _____ #Miscarriages _____ # Ectopic Pregnancies_____ #Abortions____

Any complications of labor NO / YES

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6. List all Surgeries and/or Procedures:

Month/Year	Surgeries or Procedures	Month/Year	Surgeries or Procedures

7. List all Hospitalizations:

Month/Year	Hospitalizations	Month/Year	Hospitalizations

8. Family History: ______(check) Adopted, OR Family history unknown

Provide relationship i.e. Mother, Father, Sister, Brother, Grandparent

Relationship	Living/Deceased	Age	Healthy	Medical Problem(s)
Mother	Living / Deceased		Y / N	
Father	Living / Deceased		Y / N	
	Living / Deceased		Y / N	
	Living / Deceased		Y / N	
	Living / Deceased		Y / N	
	Living / Deceased		Y / N	
	Living / Deceased		Y / N	

Breast Cancer_______________ Ovarian Cancer _______________ Colon Cancer_______________

9. Social History

Tobacco (please check one): Never smoked _____ Smoker ______ Former smoker _____

How many per day ____________________________

Alcohol: Yes ___ No ____(Circle) Occasionally / Socially / Daily____________________

Recreational Drugs: Yes ___ No ___ (Circle) Occasionally / Socially / Daily________________

Patient signature: ____Date:______________________