Complete Healthcare for Women of Wellington, LLC

Gynecology

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HISTORY & PHYSICAL

NAME (PLEASE PRINT): _____ **DATE OF BIRTH:** _____ **DATE:** _____

MEDICAL HISTORY: DO YOU HAVE ANY OF THE FOLLOWING?

Y / N HIGH BLOOD PRESSURE Y / N DIABETES
Y / N ASTHMA Y / N OTHER _____

SURGERY HISTORY:

DATE	PROCEDURE
_____	_____
_____	_____
_____	_____
_____	_____

GYNECOLOGICAL HISTORY:

LAST PAP SMEAR _____ AGE FIRST PERIOD _____
LAST MAMMOGRAM _____ AGE LAST PERIOD _____
LAST COLONOSCOPY _____ CONTRACEPTION: CURRENT _____ PAST _____
LAST BONE DENSITY _____ LOSS OF URINE? Y / N

OBSTETRICAL HISTORY:

		MONTH/YEAR	VAGINAL/C-SECTION	BABY'S WEIGHT
TOTAL PREGNANCIES	_____			
FULL TERM BIRTHS	_____	_____	_____	_____
PRETERM BIRTHS	_____	_____	_____	_____

MISCARRIAGES Y / N, IF YES HOW MANY? _____ ABORTIONS Y / N, IF YES HOW MANY? _____

MEDICATIONS:

_____ _____ _____ _____
_____ _____ _____ _____

ALLERGIES: Y / N, IF YES PLEASE LIST WITH REACTION:

_____ _____ _____ _____

SOCIAL HISTORY:

DO YOU SMOKE? Y / N, IF YES HOW MUCH? _____ ARE YOU SEXUALLY ACTIVE? Y / N
DO YOU DRINK? Y / N, IF YES HOW MUCH? _____ DO YOU EXERCISE? Y / N
ANY DRUG USE? Y / N, IF YES HOW MUCH? _____
HISTORY OF SEXUALLY TRANSMITTED INFECTIONS Y / N, IF YES PLEASE LIST _____

FAMILY HISTORY:

	ILLNESSES		ILLNESSES
MOTHER	_____	BROTHERS	_____
FATHER	_____	SISTERS	_____

ANYONE WITH: BREAST CANCER? Y / N _____ OVARIAN CANCER? Y/ N_____ COLON CANCER? Y / N_____

DO YOU HAVE A LIVING WILL? Y / N WHO IS YOUR HEALTHCARE SURROGATE? _____
PHONE _____

IMMUNIZATIONS:

TDaP _____ OPV _____ MMR _____ HIB _____ HEP B _____ HPV _____ TB _____ FLU _____ PNEUMONIA _____