WELCOME TO SEVEN HILLS WOMEN'S HEALTH CENTERS

We are asking you to complete this very comprehensive form to verify all your information so that we can convert your information to an electronic medical record.

oonvoit ye	, ar iiii		AL DATA		
Name:		D	ate:// Birth Date:		<u> </u>
Referred By:			Last 4 Digit of SS#:		Age:
Reason for visit: Routine Phy	/sical	 ☐ Proble			·
Record, Couling 1		Book 1			
·					<u> </u>
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CHECK IF YOU I	IAD A	NY OF THESE	MEDICAL PROBLEMS IN THE PAST:		· · · · · · · · · · · · · · · · · · ·
MAJOR ILLNESS	Yes	Date of Onset	MAJOR ILLNESS	Yes	Date of Onset
Abnormal PAP Smear:			GERD / Reflux / Indigestion		
Indicate treatment by circling type below			Glaucoma		
Cone Freezing LEEP Laser			Heart Trouble		
Abnormal Uterine Bleeding			Hepatitis / Jaundice		
Treatment: Ablation			Hepatitis C		
Treatment: Hysterectomy			High Blood Pressure		
Treatment: Medication			High Cholesterol		
Anemia / low blood count			Kidney Infections		
Anxiety			Kidney Stones		
Arthritis			Osteoporosis		
Asthma			Polycystic Ovarian Syndrome (PCOS)		
Blood Transfusions			Rheumatic Fever		
Blood Clots in Leg / Lungs			Stroke		
Bowel Trouble / IBS			Sexually Transmitted Diseases		
Breast Cancer			Chlamydia		
Colon Cancer			Gonorrhea		
Ovarian Cancer			Herpes	<u> </u>	
Cancer enter type:			HIV	<u> </u>	
Chronic Lung Disease			HPV	<u> </u>	
DES Exposure			Thyroid Problems	<u> </u>	
Depression			Urinary Incontinence: (see below)	↓	
Diabetes Type I or Type II (circle one)			Stress (Leakage when cough/sneeze)	<u> </u>	
Ectopic/Tubal pregnancy			Urgency (Frequent urination)	<u> </u>	
Endometriosis			Uterine Fibroid(s)	<u> </u>	
Fracture -Type:		<u> </u>	Other enter type:	<u></u>	
PLEASE LIST AN	Y OPE	RATIONS OR	HOSPITALIZATIONS YOU HAVE HAD:		
SURGERY		DATE	SURGERY		DATE
Cone Biopsy Cervix			Cesarean Section		
Bilateral Tubal Ligation					
Hysterectomy: Type (circle one)		_			
Vaginal Abdominal Laparoscopic					
Ovaries Removed (circle one)					
Both Right Left					
Diagnostic Laparoscopic					
Uterine Ablation			- Committee of the comm		-

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

DRUG NAM	E		DOSAGE	FREQUENCY	START DATE	PHYSICIAN
List the Herbal or "Natural"						
the counter drugs, and vita	imins you us	se.	ALLE	RGIES		
DO YOU HAVE ANY KNOWN ALL	ERGIES TO M	EDICATION	ONS? Yes	No If Yes, please cl	neck the list of medication	ons below.
Adhesive Tape	Erythror	nycin	Latex Glo	oves	Phenothiazines	Sulfur
Barbiturates	☐ Ethiodiz		Lidocaine	Э	Phenytoin	Tetracyclines
Carbamazepine	☐ Ethiadol		Signatur	ne (Demerol)	Cuinolones	Tuberculin Test
Cephalosporins	☐ Glucoco		e	Sulfate	Salicylates	C Other
(Keflex)	Hydroco	ortisone	A		Succinimides	
☐ Codeine ☐ Digitalis	Insulins lodine		(Advil, Alev		Sulfandurasa	
FOOD ALLERGIES SUCH	Retinitis	EGGS	# personner:	NUTS	Sulfonylureas SHELLFISH	IT COV TO VALAC
FOOD ALLERGIES SUCF			EXECUTE.	D RELATIVES H	TRIBUNG	SOY TYAMS
MAJOR ILLNESS		YES				ATE OR AGE OF ONSET
Anemia/ low blood count			TILLATIONOTI	ii 10 becob i	ELLATIVE WITH D	ATE OF AGE OF CHOLE
Anxiety			·		Name of the second seco	
Autoimmune Disease					-	
Asthma					***************************************	
Blood Clots in legs / lungs	· · · · · · · · · · · · · · · · · · ·				na congre	
Clotting Disorder						
Breast Cancer						
Colon Cancer						
Ovarian Cancer						·
Cancer enter type:						
Chronic Lung Disease						
Depression						
Diabetes						
Heart Trouble / Murmur						
High Blood Pressure						
High Cholesterol						
Osteoporosis	į.					
Stroke						
Thyroid Disease						
Other:						

GENETIC HISTORY

Complete this section if you are of child bearing years. Please indicate if any apply to you or your family history.

□ Canavan Disease □ Other Specified Disorders of Matbolism □ Spinal Cord Anomaly, Congenital □ Down Syndrome □ Other Thalassemia □ Tay-Sachs Disease □ Fragile X Syndrome □ Prader-Willi Syndrone □ Tetralogy of Fallot □ Habitual Aborter □ Septal Closure Defect □ Truncus Common □ Hemophilia □ Sickle-Cell Anemia □ Ventricular Septal Defect □ Huntington's Chorea □ Stlus Inversus □ No Genetic History □ Other - Describe: □ Spina Biffida □ No Genetic History Your OB History Number Number Total # of Pregnancies □ Full Term Births Number Number Number Total # of Pregnancies Premature Aportions Induced Miscarriages Ectopic Pregnancy/Tubal On the chart below, please fill in the answers for each pregnancy including abortions and miscarriages. □ Birth Date □ Baby's Weight/Sex Vacuum, Cosection Anes Early Wit Comments / Complications Location 1 □ M F □ M F □ M F □ M F □ M F <th>T.</th> <th>Anencepha</th> <th>alus</th> <th></th> <th>C Osteog</th> <th>genesis Imperfe</th> <th>cta</th> <th></th> <th>L.</th> <th>Spina E</th> <th>Bifida Hydrocephal</th> <th>us</th>	T.	Anencepha	alus		C Osteog	genesis Imperfe	cta		L.	Spina E	Bifida Hydrocephal	us	
□ Fragile X Syndrome □ Prader-Willi Syndrone □ Tetralogy of Fallot □ Habitual Aborter □ Septal Closure Defect □ Truncus Common □ Hemophilia □ Sickle-Cell Anemia □ Ventricular Septal Defect □ Huntington's Chorea □ Situs Inversus □ Niemann-Pick Disease □ Spina Bifida □ No Genetic History □ Other - Describe: □ Total # of Pregnancies □ Full Term Births □ Abortions Induced □ History □ On the chart below, please fill in the answers for each pregnancy Including abortions and miscarriages □ Situs Inversus □ No Genetic History □ Number □ Number □ Number □ Full Term Births □ Abortions Induced □ Living Children □ Comments / Comments / Complications □ Location □ In □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		Canavan D	isease		C Other S	specified Disorder	s of Matt	oolism	- Goddwy	Spinal	Cord Anomaly, Co	ngenital	
Habitual Aborter		Down Synd	drome		C Other	Thalassemia			Summit.	Гау-Sa	chs Disease		
□ Hemophilia □ Sickle-Cell Anemia □ Ventricular Septal Defect □ Huntington's Chorea □ Situs Inversus □ Niemann-Pick Disease □ Spina Bifida □ No Genetic History □ Other - Describe:	L	Fragile X S	Syndror	ne	☐ Prader	-Willi Syndrone				☐ Tetralogy of Fallot			
□ Huntington's Chorea □ Situs Inversus □ No Genetic History □ Other - Describe: Your OB History		Habitual Al	oorter		☐ Septal	Closure Defect	-			Truncu	s Common		
Nemann-Pick Disease Spina Biffida No Genetic History Total # of Pregnancies Premature Miscarriages Ectopic Pregnancy/Tubal Birth Date Birth Date Gest (hrs) Miscarriages Vacuum, C-section Fig. 1 Miscarriages Vacuum, C-section Miscarriages Vacuum, C-section Vacuum, C-section Miscarriages Vacuum, C-section		Hemophilia	ı		☐ Sickle-	Cell Anemia				Ventric	ular Septal Defect		
Total # of Pregnancies Number Full Term Births		Huntington	's Cho	rea	☐ Situs Ir	nversus							
Your OB History Number Number Number Number	1	Niemann-F	ick Dis	ease	☐ Spina	Bifida				☐ No Genetic History			
Number Full Term Births	Г	Other - De	scribe:						· · · · · ·			-	
Number Full Term Births												·	
Number Full Term Births	-			· 									
Number Number Number Number		<u> </u>				Your (OB His	story			<u> </u>		
Abortions Induced									•		Numbe	r	
Miscarriages Ectopic Pregnancy/Tubal Ectopic Pregnancy/Tubal Ectopic Pregnancy/Tubal Ectopic Pregnancy/Tubal Early With Date Gest Comments / Comments / Complications Comments / Complications Complicat	To	otal # of Preg	nancie	S .			Full	Term Birth	hs	•			
Comments / Complications Birth Date Gest (hrs) Baby's Weight/Sex Vag, Forceps, Vacuum, C-section Birth Date Mark Labor Gest (hrs) Baby's Weight/Sex Vag, Forceps, Vacuum, C-section C-se													
On the chart below, please fill in the answers for each pregnancy including abortions and miscarriages. Birth Date Section Baby's Weight/Sex Vag, Forceps, Vacuum, C-section Anes Early Labor? Gain Comments / Complications Location							Livir	g Childre	n				
Birth Date Wks Gest (hrs) Baby's Weight/Sex Vag, Forceps, Vacuum, C-section 1	E	topic Pregna	ancy/T	ubal									
Birth Date Gest (hrs) Baby's Weight/Sex Vacuum, C-section 1		On	the ch	art belov	w, please fill in	the answers for	each pr	egnancy ir	ncluding a	bortion	s and miscarriages		
1		1	_			Vag, Forceps, Vacuum,	Anes			-		Location	
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5 □ F 6 □ M 7 □ M 8 □ M	4				Remento								
6 □ F 7 □ M 8 □ M	5		,		9i								
7	6				₽ exxx ^E								
	7				Гм	4.000							
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Social History: Please list your life habits

Marital Status?	Married	☐ Divorced ☐ Separ	ated 🗌 Widow 🦳 Single					
Adopted/Step children in household	? ☐ Yes ☐ N	o If Yes, how many?						
Do you use a seat belt?	□Yes□N	0		*				
Do you do self breast exams?	□Yes□N	0		· · · · · · · · · · · · · · · · · · ·				
Do you eat/drink dairy products?	☐ Yes ☐ N	☐ Yes ☐ No If Yes, how many servings per day?						
Do you take calcium?		☐ Yes ☐ No If Yes, Name and Dosage?						
How often do you exercise?		☐ None ☐ Less than 3 times per week ☐ More than 3 times per week						
Are you sexually active?		☐ Yes ☐ No						
New sexual partner < 1 year?		☐ Yes ☐ No						
Number of sexual partners?	Value	Less than 5 in your lifetime More than 5 in your lifetime						
Do you smoke or use tobacco?	☐ Yes ☐ N	☐ Yes ☐ No If Yes, how many packs per day? How many years?						
Do you drink alcohol?	☐ Yes ☐ No If Yes, how	o many drinks per day?	Drinks per week?					
Do you use drugs?	If Yes, what	☐ Yes ☐ No If Yes, what kind? How often?						
Do you have a history of abuse?	☐ Yes ☐ N When:	o If Yes, 🗌 Physical	☐ Emotional ☐ Sexual					
Your type of occupation?				-				
V	/hen Was Yo	our Last Test or In	nmunization?					
	D-1-	D 11 -	1_	D.1-				
Test	Date	Results	Immunizations	Date				
Last PAP Smear	Date	Hesuits	Chicken Pox Vaccine	Date				
Last PAP Smear Bone Density - DEXA Scan	Date	Hesuits	Chicken Pox Vaccine Chicken Pox Exposure	Date				
Last PAP Smear Bone Density - DEXA Scan Cholesterol	Date	Hesuits	Chicken Pox Vaccine Chicken Pox Exposure Flu Shot	Date				
Last PAP Smear Bone Density - DEXA Scan Cholesterol Colonoscopy / Sigmoidoscopy	Date	Hesuits	Chicken Pox Vaccine Chicken Pox Exposure Flu Shot HPV Vaccine	Date				
Last PAP Smear Bone Density - DEXA Scan Cholesterol Colonoscopy / Sigmoidoscopy Mammogram	Date	Hesuits	Chicken Pox Vaccine Chicken Pox Exposure Flu Shot HPV Vaccine Pneumococcal Vaccine	Date				
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