Serenity Women's Care Confidential Medical History

Date ____/_____/_____

Name_____ Birthdate____/_____/_____ Age _____

Allergies to

Medications/food/environment	Reaction	Severity	Reaction	Onset
_____		Very Mild/Mild/Moderate/Severe	_____	Adulthood/Childhood
_____		Very Mild/Mild/Moderate/Severe	_____	Adulthood/Childhood
_____		Very Mild/Mild/Moderate/Severe	_____	Adulthood/Childhood

Current medications

Name of prescription, over the counter and herbal Reason Used	Prescribing Doctor	Dose	Instructions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History : Please complete if any of your close relatives have had any of the following:

Disease	Circle	Family Member	Family Member 1st Name	Age of onset	Age of Death	Cause of Death
Cancer of Breast	Y N	_____	_____	_____	_____	Y N
Cancer of Ovary	Y N	_____	_____	_____	_____	Y N
Cancer of Uterus	Y N	_____	_____	_____	_____	Y N
Cancer of Cervix	Y N	_____	_____	_____	_____	Y N
Cancer of Colon	Y N	_____	_____	_____	_____	Y N
Diabetes	Y N	_____	_____	_____	_____	Y N
Tuberculosis (TB)	Y N	_____	_____	_____	_____	Y N
Heart Disease	Y N	_____	_____	_____	_____	Y N
High Blood Pressure	Y N	_____	_____	_____	_____	Y N
Other	Y N	_____	_____	_____	_____	Y N

Date ____/_____/_____

Name_____ Birthdate____/_____/_____ Age _____

What do you do so you don't become pregnant?

_____ Diaphragm _____Condoms _____Sponge _____ Rhythm _____ IUD
_____ Withdrawal _____ Depo Provera _____ Vasectomy _____ Nexplanon _____Pills

_____Essure _____Tubal Ligation _____ Implanon/Nexplanon _____Ortho Evra _____Nuva Ring

Other_____

First day of your last period ____/_____/_____ What age were you when you started your first period? _____

Are your periods regular? Y N Is there bleeding between periods? Y N How often do your cycles occur? _____

For how many days do you bleed? _____

Flow is: ____ Scant ____Mild ____ Mod ____Severe ____ Incapacitating

Other symptoms with periods?
_____

Date of last pap smear ____/_____/_____ Have you had an abnormal pap smear? Y N Has this been treated? Y N

How?
_____

Do you examine your breasts regularly? Y N When was the last Mammogram (if any)? ____/_____/_____

Results _____

Do you have concerns about your breasts?
_____

When was your last Bone density test (if any)? ____/_____/_____

Results _____

Have you had:

Pain with intercourse? Y N Explain:_____

Bleeding with intercourse? Y N Explain:_____

Concerns about vaginal discharge? Y N Explain_____

Leaking of urine? Y N Explain:_____

Pelvic infections? Y N Explain:_____

Sexually transmitted diseases? Y N Explain:_____

Medical Condition Past medical (include injuries and conditions requiring medication i.e.- High blood pressure, seizures etc.)

Condition	Date	Treatment
_____	____/_____/_____	_____
_____	____/_____/_____	_____
_____	____/_____/_____	_____

Date ____/_____/_____

Name_____ Birthdate____/_____/_____ Age _____

Total number of pregnancies:

Full term _____ Premature _____ Cesarean section _____ Vaginal delivery _____ Ectopic _____

Miscarriage_____ Abortion _____ Stillborn _____ Live at birth _____ Live at present _____

Pregnancy History:

Preg#	Sex	Month/Year	# of weeks	Weight	Hrs of labor	Delivery type	Delivery Doctor	Obstetrical/Neonatal problems
_____	_____	_____/_____	_____	_____	_____	_____	_____	_____
_____	_____	_____/_____	_____	_____	_____	_____	_____	_____
_____	_____	_____/_____	_____	_____	_____	_____	_____	_____
_____	_____	_____/_____	_____	_____	_____	_____	_____	_____

Social History

Do you smoke currently? Y N Did you previously some? Y N

If yes, type of tobacco? _____Number of years? _____Packs per day? _____

How long ago did you quit? _____

Do you drink alcohol? Y N If yes, type of alcohol_____ How often? _____

Amount? _____ Last drink? _____/_____/_____

Do you consume caffeine? Y N If yes, what kind? _____ Amount? _____

Do you use recreational drugs? Y N If yes, what kind? _____ Amount? _____

Do you exercise (frequency)? ____ Daily ____ Occasional ____ 2-3 times a week ____ 4+/week ____ Never

How many sexual partners have you had? _____ Less than 5 _____More than 5

Sexual partner gender? ___ Men Only ____Women Only ____ Both

Have you been exposed to sexual or physical violence or abuse? Y N

If medically necessary, would you agree to a transfusion? Y N

Highest level of education? _____

Current Occupation?_____

Living Situation? _____ Live Alone _____ With Spouse/Significant Other _____ With Family

Marital Status? _____

Surgical History:

Surgery	Date	Reason
_____	____/_____/_____	_____
_____	____/_____/_____	_____
_____	____/_____/_____	_____
_____	____/_____/_____	_____

Date ____/_____/_____

Name_____ Birthdate____/_____/_____ Age _____

Review of Systems

If you are experiencing any of the symptoms listed, PLEASE **CIRCLE** THE ONES THAT APPLY, or write **NONE.**

Constitutional (Health in General): Fatigue, Fever, Night sweats

Ears, Nose, Mouth and Throat: Eye discharge, Vision loss, Ear drainage, Hearing loss, Nasal drainage

Respiratory: Cough, Wheezing, Difficulty breathing or Shortness of breath

Cardiovascular: Chest pain, Irregular heartbeat, Palpitations

Gastrointestinal: Abdominal Pain, Constipation, Diarrhea, Vomiting

Dermatologic: Skin itching, Rash

Muscoloskeletal: Bone weakness, Joint weakness

Hematology: Easy bleeding, Easy brusing

Immunology: Environmental allergies, Food Allergies