# LifeCircle Women's HealthCare – Health History

2301 N. Ocoee Street Cleveland TN 37311 (423) 339-1400 Fax (423) 339-9950

Date_____ Full Name_____ Maiden Name_____ Age _____

What is YOUR MAIN REASON for being seen today? _____

Did another physician refer you to us? Yes No If yes who? _____

Do you have a Primary Care Physician? Yes No If yes who? _____

Do you have other physicians? _____

Do you have a Living Will or Power of Attorney for health decisions? Yes No

Allergies: _____

Medications_____ _____

_____ _____

_____ _____

_____ _____

| Vaccines (please circle if done) | When |
|---|---|
| HPV: Gardasil / Cervarix | _____ |
| Tetanus & Whooping cough (TDap) | _____ |
| Shingles | _____ |

## Social History:

Have you ever used tobacco products: Never/Smoke/Vape/Chew Age started_____Age stopped_____Amount used _____

Do you drink alcohol? Never Rarely Moderate Daily Any history of or current concern of domestic violence? Yes No

Have you ever used illicit drugs? Yes No If yes, please specify: _____

How many years of high school completed? _____ Any College? _____

Occupation: _____ Employer: _____

Do you use a Seat Belt? Yes No Are you: Married Single Divorced Widowed Separated

## Past Medical History:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | Yes | No | Hemophilia | Yes | No | Depression | Yes | No |
| Heart Disease | Yes | No | Blood Clots (legs, lungs, ect.) | Yes | No | Anxiety | Yes | No |
| Diabetes | Yes | No | Kidney Disease | Yes | No | Seizures | Yes | No |
| Thyroid Problems | Yes | No | Hepatitis | Yes | No | Migraines | Yes | No |
| Asthma/Emphysema | Yes | No | Sexually Transmitted Diseases | Yes | No | Infertility | Yes | No |
| High Cholesterol | Yes | No | Endometriosis | Yes | No | Osteoporosis | Yes | No |

All other medical conditions: (such as cancer or liver disease) _____

## Past Surgical History:

Ever had Colonoscopy (colon test) Yes No If Yes, When? _____ Results? _____

Have you had a Hysterectomy? Yes No If Yes, Vaginal Abdominal Date _____ Reason _____

Were your ovaries removed? Yes No If Yes, Both Right Left

Have you had any other surgeries? Yes No If Yes, please list ALL surgeries below and the date of surgeries:

(Laparoscopy, Laparotomy, Cystoscopy, Trans obturator Taping. Transvaginal Taping)_____

_____

_____

_____

## Family History: Blood Relatives Only, include their relationship to you (M, F, MGM, MGF, PGM, PGF, A, U, B, S)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| High Blood Pressure | Yes | No | _____ | Cervical Cancer | Yes | No | _____ |
| Heart Disease / Surgery | Yes | No | _____ | Ovarian Cancer | Yes | No | _____ |
| Diabetes | Yes | No | _____ | Thyroid Problems | Yes | No | _____ |
| Osteoporosis | Yes | No | _____ | Breast Cancer | Yes | No | _____ |
| Blood Clots (anywhere) | Yes | No | _____ | Other (Ex cancer) | Yes | No | _____ |

## Pregnancy History: (please list the number of each)

Pregnancies _____ Premature births _____ Tubal/Ectopic _____ Miscarriages _____
Live Births _____ Abortions _____ Living Children _____

| Date of Delivery | Total # Weeks Pregnant | Hours of Labor | Weight | Sex | Vaginal or C-Sec | Method of Anesthesia | Complications | Location Of Delivery |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

## Menstrual History:

First day of last Period _____ Sure Unsure Age at first period _____ Age at menopause _____
Periods last #_____ days How many day's between periods _____ Flow: Light Medium Heavy # of heavy days _____
Are your periods regular? Yes No Any unusual bleeding? Yes No How many pads/tampons used in a day? _____

## Pap Smear:

Date of last PAP _____Normal? Yes No Done where? _____
Have you ever had an abnormal Pap smear? Yes No If yes, were biopsies taken? Yes No Dr. _____
Any surgery performed on the cervix? Yes No If yes, when? _____

## Sexual History:

Are you currently sexually active? Yes No Never If yes, with? Men Women Both
Pelvic pain with intercourse? Yes No Current birth control method: NONE or _____
Have you ever used, or currently use, hormone replacement therapy?_____ How long?_____
Have you ever been treated for any sexually transmitted diseases in the past? (If yes, please list below) Yes No
_____

## Breast Health:

Do you do self breast exams? Yes No Last Mammogram date _____ Location _____
Results: Normal Abnormal If ANY abnormal results, please give details _____

## Bone Health:

Have you ever had a bone density (DEXA) test? Yes No Results of DEXA: Normal Osteopenia Osteoporosis

Location: _____ Have you ever taken a prescription for your bones? Yes No If yes, list _____

## Review of systems: please circle any problems you are CURRENTLY having with any of the following:

| | |
|---|---|
| General: | fatigue fever weight loss weight gain body aches night sweats chills loss of appetite |
| Eyes/ENT: | vision changes headaches hearing loss sore throat sinus congestion lightheadedness |
| Breast: | lumps tenderness/pain swelling nipple discharge redness |
| Chest: | chest pain palpitations syncope/fainting |
| Respiratory: | shortness of breath wheezing cough |
| GI: | nausea vomiting diarrhea constipation blood in stool reflux |
| Pelvic: | painful periods heavy periods bleeding between periods irregular periods vaginal discharge bleeding after / pain with intercourse urgency with urination frequent urination painful urination urinary incontinence urination during night blood in urine |
| Skin: | rash dry patches changes to existing skin lesions or moles |
| Neurologic: | muscular weakness in-coordination difficulty walking tingling or numbness seizures |
| Musculoskeletal: | joint pain muscle weakness limitation of motion |
| Endocrine: | heat / cold intolerance hair loss abnormally thirsty hot flashes abnormally large amounts of urine output |
| Psych: | anxiety depression difficulty sleeping feeling confused |
| Other: | easy bruising lymph node enlargement frequent illnesses |