Womens Clinic of Lincoln, P.C. **Todays Date: _____**

Patient Health History Form

Patient's Full Name	Date of Birth	Age	Occupation	Preferred Pharmacy & Location	Other Doctors that you see & their Specialty?
					☐ ***I have no other Doctors***

Marital Status: ☐ Married (Spouse Name:) ☐ Separated ☐ Widowed ☐ Single _____ ☐ Divorced ☐ Same Sex partner

Medications & Over the Counter Vitamins andSupplements *(Please include Dosage & How often you take it)* **For prescription medication, please list who prescribes it for you**	Allergies to Medications, Foods or Substances *(Please include reaction to each & approx. year when it occurred)*
☐ No current medications	☐ No Known Drug Allergies

PERSONAL GYNECOLOGICAL HISTORY

Menstrual Cycle

Age of First Menstrual Cycle	Date that last cycle started?	Cycle Length (Ex:28 days)	# of Days cycle last? (Ex: 5 days)	Amount of cycle Flow?	How many heavy days do you have? # _____	Do you any have cramping with menses?
				☐ Light ☐ Heavy >> ☐ Moderate	How often do you change protection _____ p/day	☐ No ☐ Yes>> Rate ___

Pap Smear History

Date of Last Pap Smear: (if known)		Have you ever had an Abnormal Pap Smear :	☐ Yes>> ☐ No	Abnnormal Pap History Test/Procedure Performed?	☐ Re-pap ☐ Leep ☐ Colposcopy ☐ Cryotherapy

Are you Sexually Active?	Have you had Gardasil Vaccine?	What are you using for Birth Control?	Would you like STD testing today?	Pregnancy History:
☐ Yes ☐ No ☐ Never Have Been	☐ Yes ☐ No	☐ Pills/Ring/Patch ☐ IUD /Nexplanon ☐ Other _____	☐ Yes ☐ No	# of Pregnancies ____ # of Miscarriages _____ # of Living Children ____ # of Elective Abortions ____ ☐ Never Been Pregnant

MENOPAUSAL PATIENTS

Age of Menopause?	Have you had any Post- Menopausal Bleeding?	Are you currently taking / or have taken Hormone Replacement Therapy?
	☐ No ☐ Yes	☐ No ☐ Yes ☐ Former

HYSTERECTOMY PATIENTS

What type of Hysterectomy did you have (vaginal or abdominal) & Do you still have your ovaries?
(When and Where was your hysterectomy and done by what doctor?)

PROCEDURES and TESTING

Have you ever had a **MAMMOGRAM?**	☐ No ☐ Yes Date:_____ Location _____ Findings:_____
Do you do **SELF-BREAST EXAM?**	☐ No ☐ Yes>> How often: Occasionally /Monthly
Have you ever had a **COLONOSCOPY?**	☐ No ☐ Yes>>> Date _____ Normal ____ Abnormal ____ Follow up _____ years
Have you ever had a **DEXA/ BONE SCAN?**	☐ No ☐ Yes >> Date _____ Findings _____
Have you ever had a **PELVIC ULTRASOUND?**	☐ No ☐ Yes>> Date: _____ Reason: _____ Findings_____
Have you ever had **SCREENING BLOOD WORK DONE?**	☐ No ☐ Yes>>>When _____ Location_____

SOCIAL HISTORY

Do you smoke **CIGARETTES?**	☐ Never ☐ Former >>> Smoked for ____ years >>> Age Quit _____	☐ Yes # ____ day For how many years? _____
Are you or ever been **exposed to second hand smoke**?	☐ No ☐ Yes >> Explain:_____	Do you use **Ilicit drugs or street drugs?** ☐ No ☐ Yes>> What type? _____
Do you drink **ALCOHOL?**	☐ No ☐ Yes >> How many per week? _____	Do you drink **CAFFEINE?** ☐ No ☐ Yes> How many per day?____
Have you ever orcurrently experience **physical or verbal abuse?**	☐ No ☐ Yes>> By Whom? _____	
DIET: Do you follow an overall healthy diet with good portion control?	☐ No>> How many times a week do you eat Fast food? _____ ☐ Yes	
EXERCISE: Do you exercise for at least 30 minutes a day?	☐ No ☐ Yes >> How many times a week ? _____	

SURGICAL HISTORY:

Please list type of surgery and approximate year it was done AND ANY HOSPITALIZATIONS FOR ACCIDENTS/PROBLEMS (reason/year)

☐ *No Previous Surgeries or Hospitalizations*

Patients Name: _____ ***Date of Birth:*** _____ ***Todays Date:*** _____

PERSONAL GYNECOLOGICAL HISTORY

CONDITION	Year & Age	Details & Doctor
☐ Endometriosis		
☐ Uterine Fribroids		
☐ Ovarian Cyst		
☐ Herpes Simplex Virus		
☐ HPV		
☐ Chlamydia/Gonorrhea		
☐ Polycystic Ovarian Syndrome		
☐ Pelvic Inflammatory Disease		

PERSONAL CANCER HISTORY

CONDITION	Year & Age	Details & Doctor
☐ Breast Cancer		
☐ Ovarian Cancer		
☐ Uterine/Endometrial Cancer		
☐ Cervical Cancer		
☐ Colon Cancer		
☐ Lymphoma		
☐ Melanoma / Other type of Skin Cancer		
☐ Other:		

PERSONAL HEALTH HISTORY

*Have **YOU** ever had any of following conditions?*

CARDIAC	
☐ High Cholesterol	☐ Heart Palpitations
☐ Hypertesion	☐ Chest Pain
☐ Heart Attack	☐ Heart Diease
ENDOCRINE	***INFECTIOUS DISEASE***
☐ Hypothyroidism	☐ Influenza
☐ Enlarged Thyroid	☐ Shingles
☐ Diabetes I / II	☐ MRSA
GASTROINTESTINAL	***AUTOIMMUNE***
☐ Irritable bowel (IBS)	☐ Multiple Sclerosis
☐ Constipation	☐ Lupus
☐ Other GI Conditions:	☐ Rheumatoid Arthritis
MUSCULOSKELATAL	***RESPIRATORY***
☐ Osteopenia	☐ Asthma
☐ Osteoporosis	☐ Allergies
☐ Osteoarthritis	☐ COPD
PSYCHIATRIC	***BLADDER/KIDNEY***
☐ Anxiety	☐ Urinary Incontinence
☐ Depression	☐ Urinary Urgency
☐ Postpartum Depression	☐ Urinary Frequency
☐ Bipolar	☐ Frequent UTIs
☐ PTSD	☐ Nocturia
☐ ADHD/ADD	☐ Kidney Infections
☐ Anorexia	☐ Interstitial Cystitis
☐ Bulimia	☐ Kidney Stones
☐ Suicidal Ideations	☐ Other
NEUROLOGIC	***HEMATOLOGY***
☐ Migraine Headaches	☐ Pulmonary Embolism
☐ Seizure Disorder	☐ Anemia
☐ Parkinsons	☐ Factor V Leiden
☐ Other Conditions:	☐ Blood Clotting Disorder
PREGNANCY COMMPLICATIONS	
☐ Pre Eclampsia	☐ Pre Term Labor
☐ Gestational Diabetes	☐ Gestational Hypertension

FAMILY HEALTH HISTORY

*Has anyone in your family had ANY of the following **DISEASE/CONDITIONS?***

(PLEASE SPECIFY WHICH FAMILY MEMBER: EXAMPLE: SISTER, AUNT, ETC)

Please indicate which side of the Family and what age diagnosis	Mothers Side	Fathers Side	Age
☐ Breast Cancer			
☐ Ovarian Cancer			
☐ Uterine Cancer			
☐ Cervical Cancer			
☐ Endometriosis			
☐ Uterine Fibroids			
☐ Colon Cancer			
☐ Prostate Cancer			
☐ Hypertension			
☐ Hypothyroidism			
☐ High Cholesterol			
☐ Heart Attack			
☐ Stroke/TIA			
☐ Clotting Disorders			
☐ Deep Vein Thrombosis			
☐ Anemia			
☐ Pulmonary Embolism			
☐ Interstitial Cystitis (IC)			
☐ Lung Disease			
☐ Diabetes Type 1 (Juvenile)			
☐ Diabetes Type 2 (adult onset)			
☐ Gestational Diabetes			
☐ Anxiety or Depression			
☐ MS, Alzheimers, Dementia			
☐ Irritable Bowel Syndrome			
☐ Gallbladder Disease			
☐ Osteoporosis/Osteopenia			
☐ Kidney or Bladder Disorder			
☐ Autoimmune Disease			

*Any other **IMPORTANT OR SIGNIFICANT** details about Family Health Conditions:*

Reason for Exam Today? *And List Any other **Gynecological Concerns** you may have at this time?*

PATIENTS SIGNATURE: _____ ***TODAYS DATE*** _____

Choose your physician: *Please select the physician you wish to provide your health services. If you are seeing a nurse practioner, your physician and nurse practioner will work together to provide complete and comprehensive care.*

____ ***Dr Stephen Swanson*** ____***Dr James Maly***

Nurse Reviewed _____ *Provider Reviewed* _____ *Date* _____