The Woman's Care Center, PC

Patient Evaluation

Patient Name:	DOB:
PCP:	Pharmacy:

Personal Past/Present medical Conditions

Major Illness	Yes	Major Illness	Yes
Anemia		Heart Attack	
Arthritis/ Joint Pain		Heart Disease	
Asthma		Hepatitis	
Autoimmune Disease		High Blood Pressure	
Blood Clot(s)		High Cholesterol	
Blood Transfusion (s)		HIV/AIDS	
Bowel Problems		Kidney Infection/ Stones	
Broken Bones		Lung Disease	
Cancer Type:		Mental Disorder	
Cataracts		Reflux/ Ulcer	
Depression and/or Anxiety		Seizures/ Convulsions/Epilepsy	
Diabetes		Sexually Transmitted Disease	
Eating Disorder		Stroke	
Migraines		Thyroid Disease	

Other:

Family Medical History

Mother:	Father:
Siblings:	Aunt/Uncles:
Maternal Grandparents:	Paternal Grandparents:

Social History

Do you smoke (Circle) Cigarettes Vape Tobacco	How much _____	How many times per week do you drink alcohol?	
Do you use (circle) Cocaine Narcotics Marijuana Other	How much _____	How many days per week do you exercise?	
Diet (Circle) Poor Fair Good		How many caffeine drinks do you drink per day?	

Current Medications

Include Hormones, Vitamins, prescription & non-Prescription

Medication Name & Dosage	How Often	Medication Name & Dosage	How Often

Medication Allergies

Allergic to:	Reaction:

Outpatient Procedures & Surgeries

Procedure/Surgery	When	Procedure/Surgery	When

GYN History (please check if current or past)

Abnormal Bleeding		Hysteroscopy	
Abnormal Pap Smear Results:		Infertility	
Abdominal Surgery		Ovarian Cysts	
Breast Problems What kind:		Osteoporosis	
Cesarean Section How Many:		Sexual Problems	
Dilation & Curettage		Sexually Transmitted Disease	
Endometriosis		Uterine Abnormality	
Fibroids		Urinary Leakage	
Hysterectomy Type:		Vaginal/Vulvar Infection/Lesion	

Date of Last Pap		Date of Last Mammogram	
Date of Last Bone Density		Date of Last Colonoscopy	

Obstetric History

Age of First Period:

How often do you have periods		Full Term (Delivered after 37 weeks)	
How long are your periods		Pre-term (Delivered before 37 weeks)	
Last menstrual period (1st Day)		Multiples	
Are you currently Pregnant		Miscarriages/ Ectopics	
Menopausal Status		Elective Abortions	
Are you Sexually active		How many Living	
What do you use for Birth Control			

Pregnancy Details	#1	#2	#3	#4	#5
Pregnancy Outcome F=Full Term; P=Pre-Term; M=Miscarriage					
Delivery Date					
Weeks at Delivery					
Epidural/Anesthesia					
Delivery Type V= Vaginal; C= C-Section; VBAC					
Location/ Delivered By					
Baby Sex					
Baby Weight					

Complications of Pregnancy	#1	#2	#3	#4	#5
Gestational Diabetes					
Gestation Hypertension					
Pre-Eclampsia					
Postpartum Hemorrhage					
Preterm Labor					
Size Discrepancy					
Placenta/Amniotic Fluid					
Other:					

Please add anything that you would like to discuss with the provider that has not been previously listed.