Lifespring
women's healthcare

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Patient Medical History

Are you here for a (please check one):

Wellness Visit ☐ **Problem Visit** ☐ **Both** ☐

Print Name: ______________________________ D.O.B: ______________

Past Medical History:

Weight Loss	☐Yes ☐No	Weight Gain	☐Yes ☐No	Blood Clots	☐Yes ☐No
Blood Transfusion	☐Yes ☐No	Heart Disease	☐Yes ☐No	Bleeding Problems	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Diabetes	☐Yes ☐No	Lung Problems	☐Yes ☐No
Headaches	☐Yes ☐No	Thyroid Disorder	☐Yes ☐No	Liver Disease	☐Yes ☐No
Seizure Disorder	☐Yes ☐No	Stomach Problems	☐Yes ☐No	Cancer	☐Yes ☐No
Kidney Disease	☐Yes ☐No	Anxiety/Depression	☐Yes ☐No	Genital Herpes	☐Yes ☐No

STDs (gonorrhea, Chlamydia, syphilis, HPV, HIV) ☐Yes ☐No

Gynecological History:

Age at first period: ____________ age at last period ____________ First day of last period ____________

Number of days between periods: ____________ How many days do your periods last? ____________

Do you blood clots with your periods? ☐Yes ☐No

How many would you rate your menstrual cramps? ☐Mild ☐Moderate ☐Yes ☐No

Date of last pap smear ____________ ☐Normal ☐Abnormal

Date of last mammogram ____________ ☐Normal ☐Abnormal

Have you had a Hysterectomy ☐Yes ☐No Total or Partial When? ____________

Gynecological History:

Total number of pregnancies ________ Preterm deliveries (less than 37 weeks) ________ Miscarriages ________

Abortions ________ Number of living children ____________

	Preg. Year	Weeks Preg	MF	Birth Weight	Type of Delivery	Complications	Hospital
1.							
2.							
3.							
4.							
5.							

Medications: (Please list all medications you regularly take, including nonprescription medications)

1. ____________ 2. ____________ 3. ____________

4. ____________ 5. ____________ 6. ____________

Drug Allergies/Latex Allergies/Food Allergies:

1. ____________ 2. ____________ 3. ____________

4. ____________ 5. ____________ 6. ____________

Hospitalizations: (Please list all operations and serious illness. Do not list pregnancy admissions)

	Year	Type of Surgery or Illness	Hospital
1.			
2.			
3.			
4.			

Family History of Illness:

☐Diabetes ☐Blood clots in lungs or legs ☐High Cholesterol ☐Breast Cancer ☐Ovarian Cancer ☐Uternine Cancer

☐Other: ______________________________

Social History:

Tobacco use: Cigarettes per day ______ # of years ______ Alcohol Use: ☐Rare ☐Weekends ☐Daily

Street drug use: ☐Yes ☐No

______________________________ ______________________ ______________

Signature of patient or Legal Guardian Relationship Date