



Lexington Women's Health, P.L.L.C.

Name: _____

Date of Birth: _____

Date: _____

Age: _____

Please list the things you want to

Please list the things you want to discuss with the health care provider today/Reason for visit:

Menstrual History

When was your last period? _____

Do you bleed between periods? _____

How many days do you bleed? _____

Do you have pain? _____

Are your periods regular? _____

Do you have heavy bleeding? _____

How many days between periods? _____

Obstetric History

Number of pregnancies: _____ Living children: _____ Miscarriage/Abortions: _____

Vaginal deliveries: _____ Cesarean sections: _____

Personal Medical History

Please circle any condition that *you* have or have had:

Fibroids

Emphysema

Endometriosis

Mitral valve prolapse

Ovarian cysts

Rheumatic fever

Abnormal Pap smear

High Blood Pressure

Cervical cancer

Heart Disease

Uterine cancer

Stroke

Ovarian cancer

Deep venous thrombosis

Colon cancer

Bleeding disorder

Breast cancer

Liver disease

Fibrocystic breasts

Acid reflux

Osteoporosis/Osteopenia

Ulcers

Genital warts

Irritable bowel

HPV

Crohn's disease

Herpes

Ulcerative colitis

Chlamydia

Colonic polyps

Accidents/Injuries

Urinary tract infections

Trichomonas

Urinary incontinence

Gonorrhea

Depression/Anxiety

Yeast infections

Sexually Transmitted

Bacterial vaginosis

Cancer (type)

HIV/AIDS

Other: _____

Thyroid disease

Diabetes

Obesity

Asthma

When was your last Pap smear? _____
When was your last mammogram? _____
When was your last bone density exam? _____
When was your last colonoscopy? _____
What form of birth control do you use? _____

Surgical History

Please list any surgical procedures and the date they were performed:

1. _____
2. _____
3. _____
4. _____
5. _____

Family Medical History

Please circle any condition for which you have a **family history**:

- | | | |
|-------------------|-------------------------|-----------------|
| Uterine cancer | Clotting disorder | Thyroid |
| Ovarian cancer | Deep venous thrombosis | Tay-Sachs |
| Colon cancer | Stroke | Birth defects |
| Breast cancer | Coronary artery disease | Sickle cell |
| Osteoporosis | Cleft lip or palate | Hemophilia |
| Bleeding disorder | Open spine | Down's syndrome |
| Diabetes | Cystic fibrosis | Other |

Social History

Cigarettes per day: _____
Alcoholic beverages per week: _____
Recreational drug use: _____

Current Medications

Please include prescription, over the counter and supplements:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medical Allergies

Please include latex, iodine, eggs or shellfish if applicable:

1. _____
2. _____
3. _____

To the best of my knowledge, the information above is complete and accurate.

Patient Signature

Date