



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

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

Age: \_\_\_\_\_

**Please list the things you want to discuss with the doctor today:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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

Trichomonas

Deep venous thrombosis

Endometriosis

Gonorrhea

Bleeding disorder

Ovarian cysts

Yeast infections

Liver disease

Abnormal Pap smear

Bacterial vaginosis

Acid reflux

Cervical cancer

HIV/AIDS

Ulcers

Uterine cancer

Thyroid disease

Irritable bowel

Ovarian cancer

Diabetes

Crohn's disease

Colon cancer

Obesity

Ulcerative colitis

Breast cancer

Asthma

Colonic polyps

Fibrocytic breasts

Emphysema

Urinary tract infections

Osteoporosis

Mitral valve prolapse

Urinary incontinence

Genital warts

Rheumatic fever

Psychiatric disorders

HPV

High Blood Pressure

Sexually Transmitted

Herpes

Heart Disease

Diseases

Chlamydia

Stroke

Other: \_\_\_\_\_

Please continue to the back of the page.....

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 contraception 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	Cystic fibrosis
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

### **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.**

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Patient Signature

Date