Southern Indiana Physicians | **Women's Health**

Patient Sticker

New Obstetrics Patient

Name: ______________________ Age: ________ Date of Birth: ____________ Date: ____________

Name you wish to be called: ______________________ Occupation: ______________________

Cell Phone: ________________ Home Phone: ______________ Work Phone: ______________

PREGNANCY SUMMARY

Full Term	Premature	Abortions/Miscarriage	Ectopic	Multiple Births	Now Alive

Date	Weeks Pregnant	Hours of Labor	Birth Weight	Sex	Type of Delivery	Anesthesia?	Early Labor?	Comments/ Complications	Location/Doctor

MENSTRUAL HISTORY

First day of last menstrual period:
Age at first menstrual period:
Menstrual periods usually occur every __________ days

GYNECOLOGICAL HISTORY

Have you ever had any of the following?

Abnormal Pap .... ☐ Yes ☐ No Explain: ______________________

Breast Surgery or Problems .... ☐ Yes ☐ No Explain: ______________________

Endometriosis .... ☐ Yes ☐ No Explain: ______________________

Fibroid Tumors .... ☐ Yes ☐ No Explain: ______________________

HIV/Aids .... ☐ Yes ☐ No Explain: ______________________

Kidney Stones or problems .... ☐ Yes ☐ No Explain: ______________________

Polycystic Ovaries (PCOS) .... ☐ Yes ☐ No Explain: ______________________

Chlamydia .... ☐ Yes ☐ No Explain: ______________________

Frequent Urinary Infections .... ☐ Yes ☐ No Explain: ______________________

Genital Warts .... ☐ Yes ☐ No Explain: ______________________

Gonorrhea .... ☐ Yes ☐ No Explain: ______________________

Herpes .... ☐ Yes ☐ No Explain: ______________________

Syphilis .... ☐ Yes ☐ No Explain: ______________________

Other .... ☐ Yes ☐ No Explain: ______________________

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PATIENT MEDICAL HISTORY

Your Past Medical History					Your Family's Medical History *(including Parents, Grandparents, Aunts, Uncles, & Siblings)*		
Have you ever had	**Yes**	**No**	**Explain**		**Yes**	**No**	**Who in your family?**
Cancer							
Breast Cancer	☐	☐			☐	☐	
Cervical/Uterine/Ovarian Cancer	☐	☐			☐	☐	
Colon Cancer	☐	☐			☐	☐	
Skin Cancer	☐	☐			☐	☐	
Other Cancer	☐	☐			☐	☐	
Cardiovascular							
Bleeding Disorder	☐	☐			☐	☐	
Blood Clots in Legs/Lungs/etc.	☐	☐			☐	☐	
Blood Transfusion	☐	☐			☐	☐	
High Blood Pressure	☐	☐			☐	☐	
Heart Murmur	☐	☐			☐	☐	
Heart Attack/Disease	☐	☐			☐	☐	
Strokes	☐	☐			☐	☐	
Digestive							
Colon/Stomach problems	☐	☐			☐	☐	
Hepatitis/Liver problems	☐	☐			☐	☐	
Endocrine							
Diabetes	☐	☐			☐	☐	
Thyroid problems	☐	☐			☐	☐	
Miscellaneous							
Epilepsy	☐	☐			☐	☐	
Lupus	☐	☐			☐	☐	
Migraines	☐	☐			☐	☐	
Rheumatoid Arthritis	☐	☐			☐	☐	
Seizures	☐	☐			☐	☐	
Skin Infections	☐	☐			☐	☐	
Psychiatric							
Alcoholism	☐	☐			☐	☐	
Anxiety	☐	☐			☐	☐	
Bipolar	☐	☐			☐	☐	
Depression	☐	☐			☐	☐	
Drug Addiction	☐	☐			☐	☐	
Eating Disorders	☐	☐			☐	☐	
Schizophrenia	☐	☐			☐	☐	
Respiratory							
Asthma	☐	☐			☐	☐	
COPD/Emphysema	☐	☐			☐	☐	
Tuberculosis	☐	☐			☐	☐	

Please list any other health issues you have that are not listed above:

Past Surgeries	Date/Age	Physician

Current Medications (includes Prescribed, Herbal or OTC medications)	Dosage	Prescribing Physician

Allergy to Medications	Type of Reaction

SOCIAL HISTORY

	Yes	No	
Do you smoke?	☐	☐	If yes, age of onset: _____ # Packs per day: ______ Date quit: ________
Do you drink alcohol?	☐	☐	# Drinks per week______
Have you used recreational drugs?	☐	☐	If yes, what have you used and in what time frame?
Do you have tattoos?	☐	☐	If yes, where?
Do you have body piercings?	☐	☐	If yes, where?
Do you exercise?	☐	☐	# Days per week______
Is your mother living?	☐	☐	
Is your father living?	☐	☐	
Number of Siblings	Brothers ______ Sisters _____		
Currently employed	☐	☐	If yes, where?
Highest education level	☐ College Degree ☐ Some College ☐ HS Diploma ☐ GED ☐ Some High School		
Who do you live with?			
Marital Status	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Same Sex		