Carolina Women's Physicians
A Lexington Medical Center Physician Practice

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Lexington Medical Center

Patient History Form

Date: _____

Name:	DOB:	Race:
Home Number:	Cell Number:	Work Number:
Primary Care Physician:		

PREGNANCY HISTORY

Year	Hospital	# of Weeks	Hours/Labor	Type of Delivery	Sex of Baby	Baby Weight	Complications
				☐ Cesarean ☐ Vaginal ☐ Miscarriage ☐ Abortion			
				☐ Cesarean ☐ Vaginal ☐ Miscarriage ☐ Abortion			
				☐ Cesarean ☐ Vaginal ☐ Miscarriage ☐ Abortion			
				☐ Cesarean ☐ Vaginal ☐ Miscarriage ☐ Abortion			
				☐ Cesarean ☐ Vaginal ☐ Miscarriage ☐ Abortion			
				☐ Cesarean ☐ Vaginal ☐ Miscarriage ☐ Abortion			

FEMALE HISTORY

Have your periods stopped? ☐ Yes ☐ No	Are your periods regular? ☐ Yes ☐ No ☐ Hysterectomy ☐ Menopause
Age when period started? _____	Number of days periods last? _____
Do you miss work because of your period? ☐ Yes ☐ No	Are your periods heavy? ☐ Yes ☐ No
Do you have pain with your periods not relieved by Motrin®, Pamprin®, etc.? ☐ Yes ☐ No	Do you have a history of uterine fibroids? ☐ Yes ☐ No
Please list any sexually transmitted diseases you have had: _____	Are you sexually active? ☐ Yes ☐ No
Do you lose urine without meaning to? ☐ Yes ☐ No	Method of Birth Control? ☐ None ☐ Pills ☐ Ring ☐ Patch ☐ Mirena® IUD ☐ Paragard® IUD ☐ Implanon® ☐ Tubal ☐ Vasectomy
Do you lose urine with coughing/sneezing? ☐ Yes ☐ No	Have you had any abnormal pap smears? ☐ Yes ☐ No
Is it difficult to make it to the bathroom in time **before** having a urinary accident? ☐ Yes ☐ No	Check any of the procedures below that you have had for an abnormal pap smear: ☐ Colposcopy ☐ Cryotherapy ☐ LEEP ☐ Laser ☐ Cold Knife Cone

MEDICAL CONDITION	Age at Diagnosis	MEDICAL CONDITION	Age at Diagnosis
☐ Alcohol Abuse		☐ Kidney Disease	
☐ Allergies		☐ Infertility	
☐ Anxiety		☐ Liver Disease _____	
☐ Asthma		☐ Lung Disease _____	
☐ Bipolar Disorder		☐ Lupus	
☐ Cancer _____		☐ Premenstrual Syndrome	
☐ Clotting Disorder _____		☐ Rheumatoid Arthritis	
☐ Depression		☐ Schizophrenia	
☐ Diabetes		☐ Seizures	
☐ Drug Abuse _____		☐ Thyroid: ☐ over-active ☐ under-active	
☐ Fibromyalgia		☐ Urinary Incontinence	
☐ Glaucoma		☐ Urinary Tract Infections	
☐ Heart Disease		☐ **MRSA Infection**	
☐ Hypertension		☐ Other _____	

Signature: _____

Date: _____

MEDICATIONS

Name of Medication	Strength	How Often?	Name of Medication	Strength	How Often?

ALLERGIES

Have you had a reaction to any drug, chemical, or latex? ☐ Yes ☐ No

Please list the names of these drugs or chemicals:	Please list the type of reaction to the drug:
1.	
2.	
3.	
4.	
5.	

PAST SURGERIES

Year	Procedure	Year	Procedure
1.		5.	
2.		6.	
3.		7.	
4.		8.	

PERSONAL HISTORY

What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

What is your occupation? ☐ Student ☐ Homemaker ☐ Professional; please state job title _____

How much do you smoke? ☐ N/A _____ packs per day

How many alcoholic beverages do you drink per day? ☐ N/A _____

Do you use recreational drugs? ☐ Yes ☐ No

Have you ever had a problem with addiction to drugs or alcohol? ☐ Yes ☐ No

If so, what was your drug(s) of choice? _____

FAMILY HISTORY

Relative	**Illnesses** (mental and medical) **and age at diagnosis if known**
Mother	
Father	
Brother	
Brother	
Sister	
Sister	
Daughter	
Other:	
Other:	

Signature: _____