



A Lexington Medical Center
Physician Practice

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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
				<input type="checkbox"/> Cesarean <input type="checkbox"/> Vaginal <input type="checkbox"/> Miscarriage <input type="checkbox"/> Abortion			
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				<input type="checkbox"/> Cesarean <input type="checkbox"/> Vaginal <input type="checkbox"/> Miscarriage <input type="checkbox"/> Abortion			

FEMALE HISTORY

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

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