



*Women's Health Center of Northfield Hospital*  
 2000 North Avenue  
 Northfield, MN 55057-1697

*Patient Information Sticker*

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

## PERSONAL & FAMILY MEDICAL HISTORY

### Allergies

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### Medications

*Please list all of the medications you are taking, including any vitamins, herbal medicines, and "over-the-counter" medications.*

NAME OF MEDICATION	DOSE	FREQUENCY

### Medical History

*Please check if you have had any of the following conditions:*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Breast Lump / Biopsy         | <input type="checkbox"/> Bleeding Problems         |
| <input type="checkbox"/> Blood Clots      | <input type="checkbox"/> Migraine Headaches           | <input type="checkbox"/> High Blood Pressure       |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Stomach Problems / Ulcers    | <input type="checkbox"/> Liver Disease / Hepatitis |
| <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Heart Murmur / Heart Surgery | <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Heart Attack     | <input type="checkbox"/> Gall Bladder Disease         | <input type="checkbox"/> Cancer                    |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Depression                   | <input type="checkbox"/> Seizures                  |
| <input type="checkbox"/> Osteoporosis     | <input type="checkbox"/> Psychiatric Illness          | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Glaucoma / Eye Problem       | <input type="checkbox"/> None                      |

### Obstetric and Gynecologic History

# of Term Pregnancies: \_\_\_\_\_ # of Vaginal Deliveries: \_\_\_\_\_ # of miscarriages: \_\_\_\_\_  
 # of Pre-Term Pregnancies: \_\_\_\_\_ # C - Sections: \_\_\_\_\_ # of abortions: \_\_\_\_\_  
 # Children: \_\_\_\_\_

Are you in menopause?  YES  NO If no please complete the following:

Date of last menstrual period: \_\_\_\_\_ # of days between cycles (*first day of one to the first day of next*) \_\_\_\_\_ Length of Flow \_\_\_\_\_

Date of last Pap Smears: \_\_\_\_\_ Any abnormal Pap Smears?  YES  NO

Are you currently sexually active:  YES  NO Total # of sexual partners: \_\_\_\_\_

My partner(s) is(are):  Male  Female  Both

Have you ever had a sexually transmitted infection or pelvic inflammatory disease?  YES  NO

If yes, which one(s) \_\_\_\_\_

List any gynecologic procedures / surgeries you have had: \_\_\_\_\_

*Please check if you have had any of the following:*

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Irregular or Heavy Periods | <input type="checkbox"/> Leakage of Urine                 | <input type="checkbox"/> Painful Periods                |
| <input type="checkbox"/> Leakage of Gas or Stool    | <input type="checkbox"/> Pain / Bleeding with Intercourse | <input type="checkbox"/> Breast Lump / Pain / Discharge |
| <input type="checkbox"/> Pain with Urination        | <input type="checkbox"/> Problems with Sexual Function    | <input type="checkbox"/> Symptoms of Depression         |

**Method of Birth Control:**

- Birth Control - Pill       Condoms       Implant       Sponge / Spermicide  
 Birth Control - Patch       Diaphragm / Cap / Shield       IUD       Tubal Sterilization  
 Birth Control - Ring       Depo Provera       None       Vasectomy  
 Other

**Surgical History**

Please list all surgeries you have had, including the dates \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Social History**

Occupation: \_\_\_\_\_

Are you?     Married     Single     Divorced     Separated     Widowed     Significant Other

Highest level of education:

College       High School       GED       Other \_\_\_\_\_

Do you smoke?     YES     NO    If yes     Less than 1 Pack per Day     More than 1 Pack / Day     Other \_\_\_\_\_

How long have you smoked? \_\_\_\_\_

Do you drink?     YES     NO    If yes # of drinks per day \_\_\_\_\_

Have you ever used marijuana, cocaine, heroin, methamphetamines, or any other street drug?     YES     NO

If yes, which one(s) \_\_\_\_\_

Do you get regular exercise?     YES     NO    If yes, how often? \_\_\_\_\_

Do you have any dietary restrictions?     YES     NO    \_\_\_\_\_

Do you feel safe at home?     YES     NO

Do you want to discuss abuse?     YES     NO

**Family Medical History**

Unknown?..... YES     NO    Is the patient adopted?..... YES     NO

CONDITION	FATHER	MOTHER	SIBLING	MATERNAL GRANDPARENT	PATERNAL GRANDPARENT	CHILD
Diabetes						
Stroke						
Heart Disease						
High Cholesterol						
High Blood Pressure						
Bleeding Problems						
Blood Clots						
Breast Cancer						
Ovarian Cancer						
Uterine Cancer						
Colon Cancer						
Other Cancer						
Osteoporosis						
Depression / Mental Illness						
Drug / Alcohol Dependence						
Other Health Problems						