Northfield Hospital

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

Patient Information Sticker

Date: ___________________

PERSONAL AND FAMILY MEDICAL HISTORY

MEDICAL HISTORY

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

- ❑ Anemia
- ❑ Blood clots
- ❑ Diabetes
- ❑ Kidney disease
- ❑ Heart attack
- ❑ Asthma
- ❑ Osteoporosis
- ❑ Thyroid problems
- ❑ Breast lump / biopsy
- ❑ Migraine headaches
- ❑ Stomach problems / ulcers
- ❑ Heart murmur / heart surgery
- ❑ Gall bladder disease
- ❑ Depression
- ❑ Psychiatric illness
- ❑ Other: ___________________
- ❑ Glaucoma / eye problems
- ❑ Bleeding problems
- ❑ High blood pressure
- ❑ Liver disease / hepatitis
- ❑ Stroke
- ❑ Cancer
- ❑ Seizures

OBSTETRIC AND GYNECOLOGIC HISTORY

of pregnancies: __________ # of vaginal deliveries __________ # of miscarriages: __________

# of children: __________ # of C-sections __________ # of abortions: __________

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 period to first day of next period): __________

Date of last Pap: __________ Any abnormal Pap smears? ❑ No ❑ Yes

Are you currently sexually active? ❑ No ❑ Yes # of lifetime partners: __________

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

Have you ever had a sexually transmitted infection or pelvic inflammatory disease? ❑ No ❑ Yes

If "yes," which one(s): __________

List any gynecologic procedures / surgeries you have had: __________

Check if you have any of the following:

- ❑ Irregular or heavy periods
- ❑ Leakage of gas or stool
- ❑ Pain with urination
- ❑ Leakage of urine
- ❑ Pain / bleeding with intercourse
- ❑ Problems with sexual function
- ❑ Painful periods
- ❑ Breast lump / pain / discharge
- ❑ Symptoms of depression

Method of birth control: __________

Please list all medications (with dosages) that you are currently taking, including over-the-counter and natural or herbal supplements.

1. __________
2. __________
3. __________
4. __________
5. __________
6. __________
7. __________
8. __________

(continued, over….)

Please list any allergies you have: ______________________________

____

____

Please list all surgeries you have had, including the dates: ______________________________

____

____

SOCIAL HISTORY

Occupation: ______________________________

Marital status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Significant other

Education: ❑ Did not complete high school ❑ Completed high school ❑ Completed college ❑ Graduate degree

Do you smoke? ❑ No ❑ Yes If "yes," # of packs per day: __________ For how long? ______________________________

Do you drink alcohol? ❑ No ❑ Yes If "yes," # of drinks per day: __________

Have you ever used marijuana, cocaine, heroin, methamphetamines, or any other street drug? ❑ No ❑ Yes

If "yes," which one(s): ______________________________

Do you get regular exercise? ❑ No ❑ Yes If "yes," how often? ______________________________

Do you have any dietary restrictions? ______________________________

Have you ever been physically, emotionally, or sexually abused? ❑ No ❑ Yes

If "yes," would you like to speak with someone about this? ❑ No ❑ Yes

FAMILY MEDICAL HISTORY

Please check the box if any family member has had the following conditions:

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						