WHCA PATIENT HEALTH HISTORY

Today's Date: _____

First Name: _____ Last Name: _____ DOB: _____ Age: _____

Referred By: _____ Primary Care Physician: _____

Reason For Visit: _____

Please check any of the following health conditions that apply to YOU
(Please Specify = Example: Umbilical Hernia, Cancer of the Colon)

☐ Abnormal Pap	☐ Ovarian Cysts	☐ Fibroids	☐ Epilepsy	☐ Migraines
☐ Genital Herpes	☐ Heart Murmur	☐ Anxiety	☐ Lung Disease	☐ Liver Disease
☐ HIV	☐ Bladder Infections	☐ Heart Disease	☐ High Cholesterol	☐ Asthma
☐ Endometriosis	☐ Infertility	☐ Ulcer (specify)	☐ Thyroid Disease	☐ Breast Disease
☐ Hepatitis A, B, or C	☐ Diabetes I or II	☐ Acid Reflux (GERD)	☐ High Blood Pressure	☐ Mental Illness (specify)
☐ Vaginal Warts (HPV)	☐ Pelvic Infections	☐ Blood Clots (DVT)	☐ Hypothyroidism	☐ Bipolar Disorder
☐ Chlamydia	☐ Gonorrhea	☐ Depression	☐ Hyperthyroidism	
☐ CANCER (specify)		☐ OTHER (specify)		

All Surgeries and Dates

Type of Surgery	Date	Type of Surgery	Date

Vaccines Past Year (ex Flu)	ALL Medications & Doses	ALL Medical Allergies & Reactions

Please check ALL medical conditions that apply to your FAMILY and list their relation to you.
(Example: Diabetes-Maternal Grandfather, Type II)

☐ High Blood Pressure	☐ TWINS (Specify)	☐ Genetic Diseases	☐ Heart Disease
☐ Diabetes I or II	☐ High Cholesterol	☐ Birth Defects	☐ Heart Attacks
☐ Endometriosis	☐ Osteoporosis	☐ Mental Illness	☐ Stroke
☐ Blood Clots	☐ Hepatitis A, B or C	☐ Mental Retardation	☐ Alzheimer's
☐ Thyroid Disorder	☐ CANCER (Specify)	☐ OTHER (Specify)	☐ Pregnancy Complications

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

WHCA PATIENT HEALTH HISTORY

Are you currently sexually active? Y◯ N◯ # of Sexual Partners in the past year:

Any issues with intercourse? (Example: Pain, Dryness, Bleeding):

Do you get a period every month? Y◯ N◯

If you are Post-Menopausal, please list the age you stopped having a menstrual cycle:

Please list the 1st day of your last menstrual cycle (LMP): Age at onset of Menses:

Days bleeding Flow: Light◯ Medium◯ Heavy◯

Days in between menses Cramping: Mild◯ Moderate◯ Severe◯

Are you using anything to prevent pregnancy?
(Birth Control, Vasectomy, IUD, Nuvaring, Depo, Implant)

Last Pap Date: Result:

Last Mammogram Date: Result:

Bone Density Date: Result:

Marital Status: Single◯ Married◯ Engaged◯ Divorced◯ Domestic Partner◯

Do you perform self-breast exams? Y◯ N◯ If yes, How often?

Have you ever been a smoker? Y◯ N◯ If yes, How long?

Are you currently working? Y◯ N◯ If yes, Occupation:

Do you Exercise? Y◯ N◯ If yes, How often per week? Cardio☐ Weights☐ Yoga☐

Do you eat a specific diet? Y◯ N◯ If yes, Specify:
(Example: Gluten Free, Vegan, Vegetarian, Lactose Intollerant)

Any recreational drug use? Y◯ N◯ If yes, what kind? How often?

Do you drink Alcohol? Y◯ N◯ If yes, how often? # of Drinks?

Do you drink Caffeine? Y◯ N◯ If yes, how often? # of Drinks?

Please List All pregnancies (Include Deliveries, Miscarriages, Ectopics and Terminations)

Date Mo/Day/Year	Length of Pregnancy (Weeks)	Birth Weight and Sex	C-Section or Vaginal	Anesthesia-Show Type	Any complications with the pregnancy, labor, Delivery or Newborn