COMPLETE
WOMEN'S CARE OF ALABAMA

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Name _____

Date _____ Birthdate _____ Age _____

What is the primary reason for your visit? _____

GYNECOLOGIC HISTORY

Age at first menstrual period _____ First day of last menstrual period _____
Are cycles monthly? [ ] Yes [ ] no How many days apart? _____ How many days do you bleed? _____
Is amount of blood flow [ ] light [ ] moderate [ ] heavy Is the amount of cramping [ ] minimal [ ] mild [ ] moderate [ ] severe
Date of last pap _____ [ ] Normal [ ] Abnormal Date of last Mammogram _____ [ ] Normal [ ] Abnormal
Are you currently sexually active? [ ] Yes [ ] No Have you been in the past? [ ] Yes [ ] No
Present form of birth control: [ ] Tubal Ligation [ ] Birth Control Pills [ ] Depo Provera [ ] Nexplanon [ ] IUD [ ] Natural Family Planning
[ ] Patch [ ] Condoms [ ] Abstintence [ ] N/A Female Partner [ ] Withdrawal Technique [ ] Nuvaring [ ] Vasectomy [ ] None

MEDICAL HISTORY

Have YOU ever been diagnosed with any of the following:

[ ] Endometriosis
[ ] Genital Warts
[ ] Genital Herpes
[ ] Abnormal Pap Smear
[ ] Fibroids of the Uterus
[ ] Breast Cancer
[ ] Benign Breast Mass/Cyst
[ ] Depression
[ ] Anxiety
[ ] Other Psychiatric Diagnosis
[ ] Migraine Headaches
[ ] Seizures
[ ] Heart Disease
[ ] High Blood Pressure
[ ] Mitral Valve Prolapse
[ ] Diabetes
[ ] Hypothyroidism
[ ] Hyperthyroidism
[ ] Elevated Cholesterol
[ ] Fibromyalgia
[ ] Lupus
[ ] Deep Vein Thrombosis
[ ] Anemia
[ ] Liver Disease
[ ] Gastroesophageal Reflux
[ ] Sleep Apnea
[ ] Asthma
[ ] Pulmonary Embolus
[ ] COPD

Any unlisted medical problems? _____
What surgeries have you had? _____
Drug allergies (please also list reactions) _____
What medications are you taking? _____

OB HISTORY

Previous Pregnancies: No. of full Term Preg. _____ No. of Preterm _____ No. of Miscarriages/Abortions _____ No. of Living _____

	Month/Day/Year	Name	Sex	Weight	Vag or C/S	Anethesia	Complications
1							
2							
3							
4							
5							

FAMILY HISTORY

(Include parents, grandparents, brothers, and sisters) Do any members of your family have:

	Whom		Whom	CANCER	Whom
[ ] High Blood Pressure		[ ] Multiple Births		[ ] Breast	
[ ] Heart Disease		[ ] Diabetes		[ ] Ovaries	
[ ] Kidney Disease		[ ] Other Serious Disease		[ ] Uterus	
[ ] Liver Disease				[ ] Colon	
[ ] Depression/Anxiety				[ ] Skin	
[ ] Other				[ ] Other	

SOCIAL HISTORY

Occupation _____ Marital Status [ ] Single [ ] Married [ ] Separated [ ] Engaged [ ] Divorced Name of spouse or significant other _____

Do you smoke? [ ] Yes [ ] No how much per day? _____ How many years? _____ Do you ever drink alcohol? [ ] Yes [ ] No How many drinks per week? _____

Is there any confidential information you would like to discuss with the physician but not write down? [ ] Yes [ ] No

GENETICS HISTORY

Includes patient, baby's father, or anyone in either family with:

** Only for pregnant patients or those planning pregnancy*

	YES	NO		YES	NO		YES	NO
1. ITALIAN, GREEK, MEDITERRANEAN OR ASIAN BACKGROUND	[ ]	[ ]	7. STILLBIRTH			15. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER	[ ]	[ ]
2. SPINA BIFIDA, MENINGOMYELOCELE OPEN SPINE OR ANENCEPHALY	[ ]	[ ]	8. HEMOPHILIA	[ ]	[ ]	16. BLOOD DISORDER	[ ]	[ ]
3. DOWN SYNDROME	[ ]	[ ]	9. MUSCULAR DYSTROPHY	[ ]	[ ]	17. METABOLIC DISORDER	[ ]	[ ]
4. JEWISH BACKGROUND	[ ]	[ ]	10. CYSTIC FIBROSIS	[ ]	[ ]	18. BIRTH DEFECT NOT LISTED ABOVE	[ ]	[ ]
5. SICKLE CELL DISEASE	[ ]	[ ]	11. HUNTINGTON'S CHOREA	[ ]	[ ]	_____		
6. 2 OR MORE MISCARRIAGES	[ ]	[ ]	12. MENTAL RETARDATION	[ ]	[ ]	_____		
			13. THALASSEMIA	[ ]	[ ]			
			14. CONGENITAL HEART DEFECT	[ ]	[ ]			

Patient's Signature _____ Date _____