Women's Health & Diagnostic Center
A Lexington Medical Center Physician Practice

PATIENT HISTORY

Obstetrics and Gynecology

Date: _____

Patient Name: _____ Acct #: _____

DOB: _____/_____/_____ Age: _____ Race: _____ Marital Status: _____ Referring Physician: _____

CURRENT MEDICATIONS

See Most Recent Visit Sheet

Monthly Menstral Cycle: ☐ Yes ☐ No Frequency: _____ day(s)

ALLERGIES/TYPES OF REACTIONS

SIGNIFICANT MEDICAL DIAGNOSES/CONDITIONS

☐ Asthma ☐ Bleeding Disorder ☐ Blood Pressure ☐ Brittle Hair/Nails ☐ Cancer ☐ Cystitis ☐ Diabetes ☐ Dry Skin ☐ Epilepsy ☐ Fractures ☐ Heart Disease ☐ Hepatitis ☐ Kidney Disease ☐ STD History ☐ Thyroid ☐ Transfusions ☐ Vaginal Dryness ☐ Violence/Trauma

Sexual Activity: ☐ yes ☐ no ☐ never

☐ Other _____

PAST OPERATIVE AND INVASIVE PROCEDURES (include date)

☐ Appendectomy _____
☐ Bilateral Tubal Ligation _____
☐ D&C _____
☐ Hysterectomy _____
(specify) ☐ vaginal ☐ abdominal
☐ Ovaries Removed _____
(specify) ☐ left ☐ right
☐ Tonsillectomy _____
☐ Other: _____

LEARNING ASSESSMENT (check if applicable)

Barriers: ☐ Hearing ☐ Language ☐ Eye Sight ☐ Other _____

Preference: ☐ Verbal ☐ Written ☐ Demonstration ☐ Other _____

FAMILY HISTORY (indicate family member)

☐ Asthma _____
☐ Bleeding Disorder _____
☐ Blood Pressure _____
☐ Cancer _____
☐ Diabetes _____
☐ Epilepsy _____
☐ Genetic _____
☐ Heart Disease _____
☐ Kidney Disease _____
☐ Other: _____

SOCIAL HISTORY

Smoking _____
Alcohol _____
Recreational Drug Usage _____
Occupation _____
Other _____

PREGNANCY HISTORY

No.	Month/Year	Wt @ Birth	Wks Gestation	Hrs Labor	Delivery Type	Maternal/Newborn Complications

UROLOGICAL HISTORY (Check All that Apply)

Unable to Void
☐ Acute ☐ Chronic
☐ Resistant or slow stream
☐ Assist by strain/crede

Urgency
☐ Fear of leakage
☐ Because of pain

Leaking (wetting)
☐ Both day/night ☐ With cough/sneeze ☐ Upright
☐ Post-mict dribbling ☐ With Exercise ☐ Unconscious
☐ Conscious ☐ Supine

Frequency
☐ Day _____ times
☐ Night _____ times

Dysuria
☐ Urinary Infections

Any Previous Treatment: