Nevada Women's Care
Keeping women well with convenient, gentle care

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Patient medical history

Last name	First name	Middle name

Race	Date of birth	Age	Height	Marital status	
				O Single O Divorced	O Married O Separated

Type of visit	Details
[ ] Complication	
[ ] Routine pap smear & pelvic exam	
[ ] Family planning	
[ ] Infertility	
[ ]Pregnancy verification	

Menstrual period

Date of last menstrual period: _____

Age when you had your first period (years old):
O Younger than 10 O 10-12 O 13-15 O 16-18 O Older than 18 O Not started

Cycle (days apart):
O Less than 20 O 20-22 O 23-25 O 26-28 O 28-30 O More than 30
O None O Regular O Irregular

Flow (days of bleeding):
O 1-2 O 3-4 O 5-6 O 7 or more O None
O Light O Medium O Heavy

Spotting or bleeding between periods: O Yes O No

Current problems

Abnormal pap smear	O Yes	O No	Painful periods	O Yes	O No
Vaginal discharge	O Yes	O No	Painful intercourse	O Yes	O No
Vaginal burning or itching	O Yes	O No	Pregnancy	O Yes	O No
Vaginal infection	O Yes	O No	Blood in urine	O Yes	O No
Pelvic pain	O Yes	O No	Pain while urinating	O Yes	O No
Breast tenderness, discharge or lumps	O Yes	O No	Leak urine while coughing or laughing	O Yes	O No

Obstetrical history

Age at first pregnancy (years old):
O Younger than 16 O 16-18 O 19-21 O 22-24 O 25-27 O 28-30
O Older than 30 O Never pregnant

Live births	O None	O 1	O 2	O 3	O 4	O More than 4
Still births	O None	O 1	O 2	O 3	O 4	O More than 4
Miscarriages	O None	O 1	O 2	O 3	O 4	O More than 4
Abortions	O None	O 1	O 2	O 3	O 4	O More than 4
C-section delivery	O None	O 1	O 2	O 3	O 4	O More than 4
Vaginal delivery	O None	O 1	O 2	O 3	O 4	O More than 4
Tubal pregnancy	O None	O 1	O 2	O 3	O 4	O More than 4
Total pregnancies	O None	O 1	O 2	O 3	O 4	O 5
	O 6	O 7	O 8	O More than 8		

[Continued on the other side]

Birth control:

Please indicate the method of birth control you are presently using: O Pill O IUD O Depo O Tubal O None O Other

General medical history

Diabetes	O Yes	O No	Venereal warts	O Yes	O No
Family history of diabetes	O Yes	O No	Tuberculosis	O Yes	O No
Cancer or tumor	O Yes	O No	Convulsions	O Yes	O No
Family history of cancer or tumor	O Yes	O No	High blood pressure (hypertension)	O Yes	O No
Heart disease	O Yes	O No	Blood clot of veins (thrombophlebitis)	O Yes	O No
Kidney disease	O Yes	O No	Blood clots elsewhere (embolism)	O Yes	O No
Bladder infections	O Yes	O No	Nervousness	O Yes	O No
Liver disease (jaundice, hepatitis, cirrhosis)	O Yes	O No	Severe and / or frequent headaches	O Yes	O No
			Depression	O Yes	O No
Gonorrhea	O Yes	O No	Sickle cell disease	O Yes	O No
Syphilis	O Yes	O No	Family history of breast cancer	O Yes	O No
Chlamydia	O Yes	O No	Pregnancy glaucoma	O Yes	O No

Hospitalization and surgery

Hospitalizations:

Example: Delivery 2002, Surgery 2004

Surgeries:

Example: Appendectomy 2003, Breast augmentation

Additional information

Please list allergies or reactions to foods and medications:

Please list all medications or drugs being taken now that were prescribed by a doctor or dentist (include what you take for chronic conditions, birth control, etc.):

Please list all medication or drugs that you sometimes take, that were bought without prescription (such as aspirin, sleep medication, allergy and cold medicine, vitamins, herbal remedies, etc.):

Smoking; O Never O Less than 1 pack per day O More than 1 pack per day
Alcohol: O Never O Rarely O Sometimes O Often

Patient signature	Date	Reviewed by:

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