LEXINGTON Women's Care Chapin
A Lexington Medical Center Physician Practice

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Lexington Medical Center

Patient History

Date:_____

Name:_____ DOB:_____ Race:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Primary Care Physician:_____

Pregnancy History

Year	Hospital	# of Weeks	Hrs/ Labor	Type of Delivery	Sex of Baby	Baby Weight	Complications
				☐ Cesarean ☐ Vaginal ☐ Miscarriage ☐ Abortion			
				☐ Cesarean ☐ Vaginal ☐ Miscarriage ☐ Abortion			
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				☐ Cesarean ☐ Vaginal ☐ Miscarriage ☐ Abortion			

Female History

Have your periods stopped? ☐ Yes ☐ No

Age when periods started?_____

Do you miss work because of your period? ☐ Yes ☐ No

Do you have pain with your periods not relieved by Motrin®, Pamprin®, etc.? ☐ Yes ☐ No

Please list any sexually transmitted diseases you have had?

_____

Do you lose urine without meaning to? ☐ Yes ☐ No

Do you lose urine with coughing/sneezing? ☐ Yes ☐ No

Is it difficult to make it to the bathroom in time before having an urinary accident? ☐ Yes ☐ No

Are your periods regular? ☐ Yes ☐ No ☐ Hysterectomy ☐ Menopause

Number of days periods last?_____

Are your periods heavy? ☐ Yes ☐ No

Do you have a history of uterine fibroids? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

Method of birth control? ☐ None ☐ Pills ☐ Ring ☐ Patch ☐ Mirena® IUD ☐ Paragaurd IUD ☐ Implanon ☐ Tubal ☐ Vasectomy

Have you had any abnormal pap smears? ☐ Yes ☐ No

Check any of the procedures below that you have had for an abnormal pap smear: ☐ Colposcopy ☐ Cryotherapy ☐ LEEP ☐ Laser ☐ Cold Knife Cone

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Medical Condition	Age of Diagnosis
☐ Alcohol abuse	
☐ Allergies	
☐ Anxiety	
☐ Asthma	
☐ Bipolar disorder	
☐ Cancer:_____	
☐ Clotting disorder:_____	
☐ Depression	
☐ Diabetes	
☐ Drug abuse:_____	
☐ Fibromyalgia	
☐ Glaucoma	
☐ Heart disease	
☐ Hypertension	

Medical Condition	Age of Diagnosis
☐ Kidney disease	
☐ Infertility	
☐ Liver disease:_____	
☐ Lung disease:_____	
☐ Lupus	
☐ Premenstrual syndrome	
☐ Rheumatoid arthritis	
☐ Schizophrenia	
☐ Seizures	
☐ Thyroid ☐ over-active ☐ under-active	
☐ Urinary incontinence	
☐ Urinary tract infections	
☐ Other:_____	
☐ Other:_____	

Medications

Name of Medicine	Strength	How often?	Name of Medicine	Strength	How often?

Allergies

Have you had a reaction to any drug, chemical, or latex? ☐ Yes ☐ No

Please list the names of these drugs or chemicals:	➔	Please list the type of reaction to the drug:
1.	➔	
2.	➔	
3.	➔	
4.	➔	
5.	➔	

Past Surgeries

Procedure	Year	Procedure	Year
1.		5.	
2.		6.	
3.		7.	
4.		8.	

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Personal History

What is your marital status?

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

What is your occupation? ☐ Student ☐ Homemaker

☐ Professional, please state job title:_____

How much do you smoke? ☐ N/A _____ packs per day

How many alcoholic beverages do you drink per day?

☐ N/A _____

Do you use recreational drugs? ☐ Yes ☐ No

Have you ever had a problem with addiction to drugs or alcohol?

☐ Yes ☐ No

If so, what was your drug(s) of choice?

_____

Family History

Relative	Illnesses (mental and medical) and age at diagnosis if known
Mother:	
Father:	
Brother:	
Brother:	
Sister:	
Sister:	
Daughter:	
Other:	
Other:	

Signature:_____ Date:_____

Print Patient Name:_____ DOB:_____