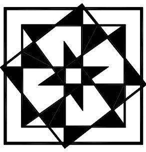

Philadelphia Women's Center Medical History

Welcome to Philadelphia Women's Center. Please take the time to fill out this form as accurately as possible so that we can best address your needs. The confidentiality of your health information is protected in accordance with our mission and values as well as federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act. You will be meeting privately with members of our medical and advocacy teams who can address any questions that you may have.

Name: ____ Date of Birth: _____________

Do you have any allergies to: ☐ Food: ____

☐ Medication: ____

☐ Latex ☐ Iodine / Shellfish ☐ I don't have any allergies

Please list any medications that you have been prescribed or have taken in the last 6 months including birth control, antibiotics, cold medications, antidepressants, anxiety medications, methadone, and Suboxone. Please include any medications that you have been prescribed and have not taken as well.

☐ I haven't taken or been prescribed any medication in the last 6 months.

Medication:	Last dose:	Why do you take this medication?
Medication:	Last dose:	Why do you take this medication?
Medication:	Last dose:	Why do you take this medication?
Medication:	Last dose:	Why do you take this medication?

Have you ever had any surgeries? ☐ Yes ☐ No

Please describe any surgeries that you've had and the years they occurred: ___________________________________

____

____

____

Have you ever had or been diagnosed with or ever had any of the following conditions? *Check all that apply.*

- ☐ Asthma
- ☐ Breathing issues
- ☐ Tuberculosis
- ☐ Heart disease or surgery
- ☐ Heart condition
- ☐ Bleeding disorders
- ☐ Anemia
- ☐ Sickle cell
- ☐ Blood clots in veins or Venous Thrombosis
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Migraines/Severe Headaches
- ☐ Diabetes
- ☐ Autoimmune Disorder
- ☐ HIV
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Kidney Problems
- ☐ Gallbladder Problems
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Liver problems (cirrhosis/jaundice)
- ☐ Cancer
- ☐ Epilepsy /neurological disorder
- ☐ Seizures
- ☐ Syphilis
- ☐ Herpes
- ☐ HPV / Warts
- ☐ Reaction to anesthesia during prior surgeries
- ☐ Other ____________________________________
- ☐ Other ____________________________________
- ☐ None

Date of last Pap (month/year): ___________________ Results: Normal / Abnormal / I don't know

Have you been diagnosed with sexually transmitted infection within the last 12 months? ☐ Yes ☐ No

☐ Chlamydia ☐ Gonorrhea ☐ PID (Pelvic Inflammatory Disease) ☐ Trichomoniasis (Trich) ☐ Other: ______________

Have you *ever* had or been diagnosed with any of the following. *Check all that apply.*

☐ An Abnormal Pap ☐ Fibroids ☐ An abnormally shaped uterus ☐ Other: ___________________________________

How many times have you been pregnant? _________

How many vaginal deliveries have you had? _________

How many c-sections have you had? _________

How many miscarriages have you had? __________

How many abortions have you had? _________

Have you had any ectopic pregnancies? Yes / No

Are you currently breastfeeding? ☐ Yes ☐ No

Have you experienced any complications with your pregnancies? Yes / No

Please explain: ____

Which types of birth control have you used? *Please check all that apply.*

☐ Condoms ☐ Pills ☐ Patch ☐ Nuva Ring ☐ Depo ☐ IUD (Mirena/Paragard/Skyla)

☐ Implant (Implanon/Nexplanon/Norplant) ☐ Fertility Awareness Method (Rhythm Method) ☐ None

☐ Other____

What kinds of birth control would you like more information about? ____

Name: ____ Date of Birth: ____________

Have you ever seen a counselor, therapist or psychiatrist? ☐ Yes ☐ No Date of last visit: ______________

Have you ever been diagnosed with or experienced any of the following? *Please check all that apply.*

☐ Depression ☐ Anxiety or Panic Disorder ☐ Bipolar Disorder

☐ Post Traumatic Stress Disorder (PTSD) ☐ Anger Management Issues ☐ Hospitalization for mental health reason(s)

☐ Attempted suicide ☐ Suicidal thoughts ☐ Other: ______________________________

Have you ever been hit, slapped, kicked or otherwise physically hurt by someone?

☐ No ☐ Yes, in the past year ☐ Yes, more than one year ago

Has anyone ever forced you into sexual activity that made you feel uncomfortable? ☐ Yes ☐ No

Have you used recreational drugs in the last 3 months? ☐ Yes ☐ No

If yes, which drugs: ____

Are you currently in a drug treatment program or taking medication for drug treatment? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No How many alcoholic drinks do you usually have in a week? ______

How many cigarettes/cigars do you smoke per day? _____________ ☐ I don't smoke

Do you have any concerns or questions that you would like to ask regarding your medical history and how it may affect the care that Philadelphia Women's Center provides? ☐ Yes ☐ No

____

____

____

Patient Signature: ____ Date: ______________ Time: ___________

RN Signature: ____ Date: ______________ Time: ___________