

**Louisiana Women's Healthcare Associates, LLC
HEALTH HISTORY FORM**

Name: _____ Date: _____ Reason for Today's Visit _____

PLEASE LIST

Allergies	Current Medications	Previous Surgery

SCREENING TESTS

Test	Date/Year	Normal	Abnormal	HAVE YOU EVER HAD THE FOLLOWING:	
Pap Smear				<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures
Mammogram				<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis/Jaundice
Bone Scan				<input type="checkbox"/> TB	<input type="checkbox"/> Thrombophlebitis/Blood Clots
Colon Cancer				<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sexually Transmitted Diseases
Cholesterol				<input type="checkbox"/> Asthma	<input type="checkbox"/> Any other serious illness/injury

Personal History:

Do you eat a well balanced diet? _____ Do you smoke? _____
 Do you drink alcohol? _____ Do you exercise? _____
 Have you ever been treated for alcoholism? _____ Do you feel rested after sleep? _____
 Do you have a history of drug abuse? _____ Have you recently experienced domestic violence or feel threatened? _____
 Have you every been treated for drug abuse? _____

Menstrual History:

Age first period began _____ Date last period began _____
 Cycle length (example 28 days) _____ Irregular periods? _____
 Number of days of flow _____ Bleed between periods? _____
 How old were you when you had your first full term pregnancy _____ Heavy flow/clots/cramps? _____

PREGNANCY HISTORY

Year of Delivery	Full Term Premature Stillborn Miscarriage Abortion C-section Vaginal Del. VBAC	List Complications i.e. High Blood Pressure, Tubal Pregnancy, Gestational Diabetes, etc.	Sex of Child	Weight of Child
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FAMILY HISTORY

Family Member	Illnesses or Medical Conditions	Age at Death	Cause of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

WHO IN YOUR FAMILY (Living or Deceased) HAS OR HAD THE FOLLOWING:

Cancer	Inherited Diseases	Diabetes
Breast Cancer	Birth Defects	Epilepsy
Ovarian Cancer	Sickle Cell Anemia	Heart Disease
Uterine Cancer	Mental Retardation	High Blood Pressure
Other Female Cancer	Any other inherited diseases	Mental Illness
Colon Cancer		TB (Tuberculosis)