LOUISIANA WOMEN'S Healthcare | Ochsner

Physician: _____ Date: _____

Reason for Today's Visit: _____

Patient Name: _____

DOB: _____ Gender: _____

MRN: _____

CSN: _____

AFFIX LABEL HERE

HEALTH HISTORY FORM

Please List:

Allergies	Current Medications	Previous Surgery

Screening Tests:

Test	Date/Year	Normal	Abnormal	Have You Ever Had the Following?	
Pap Smear				❑ **High Blood Pressure**	❑ **Seizures**
Mammogram				❑ **Heart Disease**	❑ **Hepatitis/Jaundice**
Bone Scan				❑ **TB (Tuberculosis)**	❑ **Thrombophlebitis/ Blood Clots**
Colon Cancer				❑ **Diabetes**	❑ **Sexually Transmitted Diseases**
Cholesterol				❑ **Asthma**	❑ **Any Other Serious Illness/Injury**

Personal History:

Do you eat a well-balanced diet? **Y / N**

Do you drink alcohol? **Y / N**

Have you ever been treated for alcoholism? **Y / N**

Do you have a history of drug abuse? **Y / N**

Do you smoke? **Y / N**

Do you exercise? **Y / N**

Do you feel rested after sleep? **Y / N**

Menstrual History:

Age first period began? _____

Cycle length? (example: 28 days) _____

Number of days of flow? _____

Date last period began? _____

Irregular periods? **Y / N**

Bleed between periods? **Y / N**

Heavy flow/clots/cramps? **Y / N**

Have you recently experienced domestic violence or feel threatened? **Y / N**

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Pregnancy History: How old were you when you had your first full term pregnancy? _____

Year of Delivery	Full Term	Premature	Stillborn	Miscarriage	Abortion	C-Section	Vaginal Delivery	VBAC	List of Complications *i.e. high blood pressure, tubal pregnancy, gestational diabetes, etc.*	Sex of Child	Weight of Child
	❑	❑	❑	❑	❑	❑	❑	❑			
	❑	❑	❑	❑	❑	❑	❑	❑			
	❑	❑	❑	❑	❑	❑	❑	❑			
	❑	❑	❑	❑	❑	❑	❑	❑			
	❑	❑	❑	❑	❑	❑	❑	❑			

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	Other Diseases	
Breast Cancer	**Birth Defects**	**Epilepsy**
Ovarian Cancer	**Heart Disease**	**Mental Illness**
Uterine Cancer	**High Blood Pressure**	**Intellectual Disability**
Other Female Cancer	**Diabetes**	**TB (Tuberculosis)**
Colon Cancer	**Sickle Cell Anemia**	
Any Other Inherited Diseases: _____		