

Azalea Women's Healthcare

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Date _____

HISTORY FORM

Legal Name _____

Date of Birth _____ Previous last names _____

Ethnic background _____

Any cultural or religious beliefs that may affect your medical care? _____

Emergency contact(s) name _____

Address and phone number of emergency contact _____

Reason for office visit today (yearly physical, problem visit, consultation, etc.)

Date of Last Pap Smear ____/____/____

Date of Abnormal Pap Smear ____/____/____

Please provide approximate dates of any previous radiological examinations from the list below:

Mammogram ____/____/____

Bone density ____/____/____

Colonoscopy ____/____/____

Have you had any of the following immunizations/vaccines:

Gardasil _____

MMR (Measles, Mumps, Rubella) vaccine _____

Tetanus vaccine booster _____

Meningitis _____

Have you had the Chicken Pox or been vaccinated for it? _____

Please list any medical conditions you may have (asthma, diabetes, hypertension, STD's, etc.):

Please list any surgical procedures/operations you have had and the dates they were performed:

Date

Operation

SOCIAL HISTORY:

Do you ever drink alcohol? Yes/No How often on average? _____ How many drinks per time? _____

Have you ever smoked? Yes/No How many years? _____ How many per day? _____ When did you quit? _____

Do you use any other non-prescription drugs? Yes/No If yes, what type? _____

How old were you when you had sex for the first time? _____

How many sexual partners have you had in your lifetime? (circle one) 0 – 1 2 – 5 More than 5

Last grade completed? _____ Did you attend college? Yes/No

How did you find out about or choose us? (circle one)

Physician Friend Yellow Pages Internet Newspaper Azalea Website WCTV HealthLinks Other _____

What is your occupation? _____

What is your marital status? (circle one) Single Dating Engaged Married Divorced Widowed

FAMILY HISTORY

List any family members (blood relatives only) with the following medical problems (list relationships, ie mother (M), father (F), sister (S), brother (B), maternal grandmother (MGM), maternal grandfather (MGF), paternal grandmother (PGM), paternal grandfather (PGF), etc.)

CARDIAC

Stroke _____
Heart disease _____
High blood pressure _____
High cholesterol _____
Blood clots _____
Pulmonary embolism _____

NEOPLASMS/MALIGNANCY

Ovarian cancer _____
Uterine cancer _____
Breast cancer _____
Colon cancer _____
Other malignancy _____
Cervical cancer _____

DIGESTIVE/GASTROINTESTINAL

Celiac disease _____
Colon polyps _____
Familial polyposis _____
Ulcerative colitis _____
Crohn’s disease _____
Hepatitis _____

NEUROLOGIC

Alzheimer’s disease _____
Parkinson’s disease _____
Seizure disorder _____

ENDOCRINE

Diabetes (sugar) _____
Thyroid disorder _____
Graves disease _____

PSYCHIATRIC

Bipolar disorder _____
Depression _____
Schizophrenia _____
Alcoholism _____

HEMATOLOGIC

Factor VIII disorder _____
Von Willebrand’s disease _____
Sickle cell disease/trait _____
Hereditary spherocytosis _____

RESPIRATORY

Tuberculosis _____
COPD _____
Emphysema _____
Lung Cancer _____

MUSCULOSKELETAL

Arthritis _____
Osteoporosis _____
Osteopenia _____

OTHER

Cystic fibrosis _____
Scleroderma _____
Lupus _____

OFFICE ONLY: Height ____' ____" **Weight** _____ **BP** ____/____ **HGB** _____ **U/A** _____ **Temp** _____ **G** _____ **P** _____

NOTES: