Women's Health Specialists and Midwives of Dayton

Patient History

New Established

Name	**Age**	**Single Married** **Widowed Divorced**
Employer		
Occupation: **DOB:**	**Advance Directives: Yes_____No_____**	

Last Menstrual Period____________________Having Periods ______________________________

Breast Feeding____

Allergies:____

____

Reactions to allergies:____

Chief Complaint:____

____

Current Medications:____

____

____

Personal Medical History:	**yes**	**No**		**Yes**	**No**		**Yes**	**No**
Abnormal Pap			Depression			Seizures		
Anemia			Diabetes Type I			Sensitization		
Anesthesia Complication			Diabetes Type II			Substance Abuse		
Asthma			Hepatitis			Thyroid Disease		
Anxiety			HIV			Trauma/Violence		
Breast Problems			Elevated Lipids			Uterine Anomaly		
Coronary Artery Disease			Hypertension			Varicosities/Phlebitis		
Cancer			Infertility			Other		
Congestive Heart Failure			Kidney Disease					
Chronic Obstructive Pulmonary Disease			Psychiatric					

Surgical History:____

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Please Complete Other Side

Social History:	Smoker: pks/day	Alcohol Use: oz/week	Drug Use:	Sexually Active:	Domestic Violence

Family History:	MO	FA	Sis	Bro	MGM	MGF	PGM	PGF	other
ADHD									
Alcohol/Drug									
Allergies									
Anesthesia									
Asthma									
Autism									
Blood Clots									
Blood Diseases									
Bipolar									
Breast CA									
Cancer									
Cerebral Palsy									
CHF									
COPD									
Dementia									
Depression									
Diabetes									
Genetic									
GI									
GU									
Heart Disease									
Hyperlipidemia									
Hypertension									
Thyroid Disease									
Stroke									
Other Medical Problems									

Pregnancy History:	
Number of times Pregnant	
Number of Pregnancies Completed	
Number of Pregnancies Completed to Term	
Number of Pregnancies Completed preterm	
Number of Abortions:	**Induced: Spontaneous:**
Number of Living Children	

Patient or Guardian Signature:____

Date:____