Tomball Woman's Healthcare Center

Name:_____
DOB:_____

Pharmacy Name and Phone:_____

Primary Care Physician and Phone: _____

Current Medications:

Name	Dose	Frequency	Reason for taking

Past Medical Health Problems:

Allergies: Please list the name (medication and food) and type of reaction

GYN History:

Last pap smear	Date:_____ ☐ Normal ☐ Abnormal
History of Abnormal pap smear	Yes ☐ No ☐ Treatment:_____
Sexually active *(if yes age at first time)*	☐ Yes _____ ☐ No ☐ Not Currently
Birth control *(including vasectomy)*	
History of STD	☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Trichomonas ☐ HIV _____
Last Colonoscopy	Date:_____ ☐ Normal ☐ Abnormal
Last Bone Density	Date:_____ ☐ Normal ☐ Abnormal
Last Mammogram	Date:_____ ☐ Normal ☐ Abnormal
Last Menstrual Cycle	Date:_____ ☐ Normal ☐ Abnormal
Length of Cycle/Frequency of cycle	_____/_____
Are your cycles painful?	☐ Yes ☐ No ☐ Not Currently
Hysterectomy	☐ Abdominal ☐ Vaginal ☐ Robotic
Age of Menopause	

Are/have you used hormone replacement	

Pregnancy History: Include any miscarriages, abortions, and ectopic pregnancies

Date	Weeks	Birth Weight	Gender	Type of delivery	Complications

Surgical History:

Date	Type of Surgery

Hospitalizations:

Date	Reason / Length of Stay

Family Health History: *If yes, who and what age of diagnosis*

Diabetes:	**Breast Cancer:**
Hypertension:	**Ovarian Cancer:**
Heart Disease:	**Colon Cancer:**
Heart Attack:	**Lung Cancer:**
Stroke:	**Genetic Disorder:**
High Cholesterol:	**Other:**

Social History:

Alcohol: ☐ No ☐ Yes ***If yes:*** *How many at a time?_____ How many per week?_____*
Tobacco: ☐ Never ☐ Former ☐ Currently *How many a day?_____ How many years?_____*
Exercise: ☐ No ☐ Yes How Often?_____
Married: ☐ Single ☐ Married ☐ Engaged ☐ Divorced ☐ Widowed ☐ Domestic Partner
Drugs: ☐ No ☐ Yes If yes how often?
Caffeine: ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drinks *How many?_____ How Often?_____*
Diet: ☐ Regular ☐ Vegan ☐ Gluten Free ☐ Dairy Free ☐ Other:_____

Occupation: