Lake Barrington
WOMEN'S HEALTH CENTER, PC

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OBSTETRICS & GYNECOLOGY

MEDICAL HISTORY

NAME ____

DATE OF BIRTH ______________ HEIGHT ________ WEIGHT __________

ALLERGIES _________________________ SMOKING _____________

FAMILY HISTORY: (please list family member)

DIABETES ____________________________________

CANCER (type/family member) __________________________

HEART DISEASE ________________________________

ELEVATED CHOLESTEROL ___________________________

GENETIC DISORDERS _____________________________

OSTEOPOROSIS _________________________________

THYROID DISORDER ______________________________

OTHER _______________________________________

PERSONAL HISTORY

MEDICAL HISTORY ______________________________

HOSPITALIZATIONS _____________________________

SURGICAL HISTORY _____________________________

ABNORMAL PAP SMEARS __________________________

LAST PAP SMEAR _______________________________

LAST MAMMOGRAM ______________________________

LAST BONE DENSITY _____________________________

LAST COLONOSCOPY _____________________________

LAST CHOLESTEROL SCREENING ______________________

MEDICATION LIST ______________________________

____

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TYPE OF DELIVERY DATE

PREGNANCIES __________________________________

____

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SIGNATURE __________________________ **DATE** ____________

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