VISTA WOMEN'S HEALTHCARE
A Lexington Medical Center Physician Practice

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VistaWomens.com

Lexington Medical Center

Patient History Form

Name:	Chart#:	Age:	Date:
Primary Care Physician:	Referring Physician:		
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widow ☐ Divorced			
Reason for visit:			

Gynecological History

Age period began:	Date of last menses:	Are menses regular? ☐ Yes ☐ No
Number of days between menses:	Number of days bleeding:	Do you have pain with periods? ☐ Yes ☐ No
Are you sexually active? ☐ Yes ☐ No	☐ heterosexual ☐ homosexual ☐ bi-sexual	
Current Birth Control Method:	What other methods have you used in the past?	Heavy flow/clots? ☐ Yes ☐ No
Have you ever been diagnosed with an STD? ☐ Yes ☐ No	What? When?	Have you been tested for HIV (AIDS)? Results: ☐ Positive ☐ Negative
Date of last pap:	Results: ☐ Normal ☐ Abnormal	
Have you ever had an abnormal smear? ☐ Yes ☐ No	How was it treated?	
Date of last mammogram:	Results: ☐ Normal ☐ Abnormal	
Date of last colon cancer screening:	Date of last bone density study:	
Have you had recent blood work to check cholesterol, glucose, and thyroid? ☐ Yes ☐ No		
Have you had any of the following vaccines in the past 10 years? ☐ Shingles vaccine ☐ HPV vaccine ☐ Tetanus/diphtheria vaccine ☐ Hepatitis B		

Obstetric History

Total number of pregnancies: _____ Miscarriage: _____ Abortions: _____ Living Children: _____

Any complications of pregnancy or delivery?

Did you have gestational diabetes? ☐ Yes ☐ No	Hypertension? ☐ Yes ☐ No	Preeclampsia? ☐ Yes ☐ No

No.	Birth Date	Male/Female	Birth Weight	Type of Delivery	No.	Birth Date	Male/Female	Birth Weight	Type of Delivery
1					4				
2					5				
3					6				

Current Medications (Also include all vitamins, herbs, and any frequently used over-the-counter medications)

Drug Name:	Dosage:	Prescribed by:	Drug Name:	Dosage:	Proscribed by:

☐ **Attached Medication List**

Allergies: (Drug name and reaction)			
Drug Name	Reaction	Drug Name	Reaction
Do you have a latex allergy? ☐ Yes ☐ No			

Medical History			
Illness	Date	Illness	Date

Surgical History			
Surgery	Date	Surgery	Date

Social History			
Do you smoke? ☐ Yes ☐ No	How much?	How many years?	
Do you drink alcohol? ☐ Yes ☐ No		How many drinks in a week?	
Do you use street drugs? ☐ Yes ☐ No		What type and how often?	
Any history of sexual or physical abuse? ☐ Yes ☐ No		What is your current occupation?	

Family History			
Father: ☐ Living ☐ Deceased	Cause of death:	Age of death:	
Mother: ☐ Living ☐ Deceased	Cause of death:	Age of death:	
☐ Family history unknown			
Is there a family history of the following? (Please list affected family members)			
☐ Diabetes		☐ Stroke	
☐ Hypertension		☐ Heart disease	
☐ High Cholesterol		☐ Blood clots in legs/lungs	
☐ Osteoporosis		☐ Breast cancer	
☐ Colon cancer		☐ Ovarian cancer	
☐ Uterine cancer		☐ Mental illness/depression	
☐ Thyroid		☐ Endometriosis	
☐ Fibroids			

Review of systems (Please check yes if you are currently experiencing the symptoms below)					
Symptom		**Symptom**		**Symptom**	
Weight loss/gain	☐ Yes ☐ No	Irregular heartbeat	☐ Yes ☐ No	Fatigue	☐ Yes ☐ No
Constipation/diarrhea	☐ Yes ☐ No	Visual problems	☐ Yes ☐ No	Urinary leakage	☐ Yes ☐ No
Chest pain	☐ Yes ☐ No	Frequent urination	☐ Yes ☐ No	Difficulty breathing	☐ Yes ☐ No
Painful urination	☐ Yes ☐ No	Joint/muscle pain	☐ Yes ☐ No	Frequent headaches	☐ Yes ☐ No
Breast pain	☐ Yes ☐ No	Depression/anxiety	☐ Yes ☐ No	Breast discharge	☐ Yes ☐ No
Hot flashes	☐ Yes ☐ No	Abnormal thirst	☐ Yes ☐ No	Hair loss	☐ Yes ☐ No