Hancock Women's Center Adolescent Patient History

PATIENT NAME: _____ DOB: _____ TODAYS DATE: _____

REASON FOR VISIT: _____

**********GYNECOCOLOGIC HISTORY**********

LAST MENSTRUAL CYCLE: _____

LAST PAP SMEAR: _____ LAST MAMMOGRAM: _____

LAST BONE MINERAL DENSITY: _____ LAST COLONOSCOPY: _____

CURRENT BIRTH CONTROL METHOD: _____ EVER HAD SEX? ☐ YES ☐ NO

RECENT CHANGES IN PERIOD? ☐ YES ☐ NO CURRENTLY SEXUALLY ACTIVE? ☐ YES ☐ NO

EXPLAIN: _____ MORE THAN ONE SEXUAL PARTNER? ☐ YES ☐ NO

CHECK (✔) PROBLEMS/CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST:

☐ Irregular periods	☐ Painful intercourse	☐ Abnormal mammogram	☐ Abnormal pap smear	☐ Syphilis
☐ Bleeding between periods	☐ Bleeding with intercourse	☐ Abnormal nipple discharge	☐ Urinary problems (UTI, etc.)	☐ Human Papilloma Virus
☐ Extreme menstrual pain	☐ Fibroids	☐ Breast lump	☐ Herpes Simplex Virus	☐ Trichomonas
☐ Pelvic infection	☐ Uterine abnormalities	☐ Breast pain	☐ Chlamydia	☐ Hepatitis
☐ Vaginal infection	☐ Infertility	☐ Hot flashes	☐ Gonorrhea	☐ HIV / AIDS

☐ Other: _____

**********OBSTETRIC HISTORY**********

PREGNANCIES: _____ # ABORTIONS: _____ # MISCARRIAGES: _____

LIVE BIRTHS: _____ # LIVING CHILDREN: _____ # PREMATURE (<37wks): _____

BIRTH DATE	SEX	BIRTH WT	# WKS PREG	TYPE OF DELIVERY	COMPLICATIONS
__/__/__	☐ / ☐	___lb ___oz	_____	☐ Vaginal ☐ C-Section	_____
__/__/__	☐ / ☐	___lb ___oz	_____	☐ Vaginal ☐ C-Section	_____
__/__/__	☐ / ☐	___lb ___oz	_____	☐ Vaginal ☐ C-Section	_____
__/__/__	☐ / ☐	___lb ___oz	_____	☐ Vaginal ☐ C-Section	_____
__/__/__	☐ / ☐	___lb ___oz	_____	☐ Vaginal ☐ C-Section	_____

CHECK (✔) PROBLEMS/CONDITIONS YOU HAVE OR HAVE HAD DURING AND FOLLOWING PREGNANCY:

☐ Diabetes ☐ Preeclampsia/Toxemia ☐ "Baby Blues" / Post-partum depression ☐ Other: _____

☐ High blood pressure ☐ Recurrent miscarriage Treatment: _____ _____

**********GENERAL MEDICAL HISTORY**********

Surgical History: _____

_____

CHECK (✔) PROBLEMS/CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST:

☐ Alcoholism	☐ Anorexia	☐ Arthritis	☐ Asthma	☐ Blood clot disorder	☐ Bronchitis	☐ Bulimia	☐ Cancer
☐ Cataracts	☐ Chicken pox	☐ Depression	☐ Diabetes	☐ Drug abuse	☐ Emphysema	☐ Epilepsy	☐ Gallbladder disea
☐ Glaucoma	☐ Goiter	☐ Heart Disease	☐ Gout	☐ Heart attack	☐ Hernia	☐ High cholesterol	☐ Hyperthyroid
☐ Hypothyroid	☐ Hypertension	☐ Kidney Disease	☐ Measles	☐ Liver Disease	☐ Lung Disease	☐ Migraines	☐ Mononucleosis
☐ Mitral valve prolapse	☐ Osteoporosis	☐ Osteopenia	☐ Ulcers	☐ Pacemaker	☐ Pneumonia	☐ Rheumatic fever	☐ Scarlet fever
☐ Staph infection	☐ Stroke	☐ Suicide attempt	☐ Mumps	☐ Tonsillitis	☐ Cholesterol	☐ Other: _____	

CURRENTLY SMOKE? ☐ YES ☐ NO EVER SMOKE? ☐ YES ☐ NO # YEARS: _____ # PACKS/DAY: _____ QUIT DATE: _____

CURRENT MEDICATIONS & DOSAGE: _____

_____

_____

DRUG ALLERGIES: _____

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By signing below, I verify the information stated above is true and accurate to the best of my knowledge.

_____ _____

Patient / Guardian Signature *Date*

☐ *The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability and admissibility.*