LifeSprings Women's Healthcare

New Patient History

Today's Date:_____

Patient Name: _____ DOB: _____ Age: _____

Past Medical History: Please check any of the following conditions you have had.

Neuropsychiatric:

_____ Depression
_____ Anxiety
_____ Eating Disorder
_____ Stroke
_____ Seizures
_____ Migraines

Cardiovascular:

_____ Heart Murmur
_____ High Blood Pressure
_____ Heart Attack
_____ Irregular Heartbeat
_____ Rheumatic Fever
_____ Anemia
_____ Palpitations
_____ Congestive Heart Failure

Endocrine/Rheum:

_____ Diabetes
_____ Menopause
_____ Elevated Cholesterol
_____ Thyroid Disease
_____ Gout
_____ Arthritis
_____ Rheumatoid Arthritis
_____ Lupus
_____ Fibromyalgia

GI:

_____ Hepatitis
_____ Heartburn
_____ Diverticulosis
_____ Hemorrhoids
_____ Ulcer
_____ Colitis/Crohn's Disease
_____ Irritable Bowel
_____ Gallstones

Gynecological:

_____ Pelvic Pain
_____ Herpes
_____ Gonorrhea
_____ Chlamydia
_____ Gential Warts
_____ HIV/AIDS

Pulmonary:

_____ Asthma
_____ COPD
_____ TB

Cancer:

_____ Breast
_____ Skin
_____ Colon
_____ Other: _____

Others: _____

_____

_____

Obstetrical/Gynecological History

Last menstrual period (Month/Day/Year) : _____

Obstetrical/Gynecological History

Last menstrual period (mm/dd/yyyy): _____

Age at which menses began: _____

Presently Breastfeeding: Yes No

Number of pregnancies:_____

Number of children: _____

Pregnancy complications: _____

_____

Number of miscarriages or abortions: _____

Current birth control method: _____

Have you had a hysterectomy: Yes No Do you have your ovaries: Yes No

Previous abnormal Pap smear: Yes No If yes, when? _____

Last Pap smear (mm/dd/yyyy):_____

Last Mammogram (mm/dd/yyyy)_____ Normal? Yes No

Last bone density (DEXA) scan (mm/dd/yyyy):_____ Normal?Yes No

Previous Immunizations

_____ MMR _____ Hepatitis B _____ Pneumovax _____ Tetanus _____ Tdap _____Gardasil

Have you ever had a colonoscopy? Yes No If yes, what year: _____ Normal? Yes No

Have you ever required a blood transfusion: Yes No If yes, what year: _____

Current Medications:

Name of Medicine	Dose	How Often

Medication Allergies/Reaction: _____

_____

Hospitalizations/Surgeries/Procedures:

Type	Year

Primary Care Physician/Phone Number: _____

Pharmacy Name/Phone Number or Location:_____

Emergency Contact Name/Phone Number: _____

Under HIPPA Guidelines, I authorize this office to discuss my protected health information for any purpose with the following person(s):

_____ _____

Name Relation

_____ _____

Name Relation

_____ _____

Patient Signature Date