Chart Number _____

Athens Women's Clinic

817 Cook Drive
Athens, TN 37303
Phone: (423) 745-3394

Date _____ / _____ / _____

Patient Name _____ Date of Birth _____ / _____ / _____

Why are you seeing the doctor today? _____

Allergies

Do you have an allergy to any medications? ❑ Yes ❑ No Are you allergic to Latex? ❑ Yes ❑ No

If yes, list medication and reaction: _____

_____

Do you have any environmental / food allergies? ❑ Yes ❑ No

If yes, please list: _____

Past Medical History of Patient

Have you ever had or do you presently have any of the following?

Abnormal Mammogram	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No
Breast Problems	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No
Abnormal Pap Smear	❑ Yes	❑ No	History of Heart Attack	❑ Yes	❑ No
Endometriosis	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No
Sexually Transmitted Disease	❑ Yes	❑ No	High Blood Pressure in pregnancy	❑ Yes	❑ No
Osteoporosis	❑ Yes	❑ No	High Cholesterol	❑ Yes	❑ No
Osteopenia	❑ Yes	❑ No	Hepatitis A, B, or C	❑ Yes	❑ No
Lupus	❑ Yes	❑ No	Stomach, colon, or liver problems	❑ Yes	❑ No
Sickle Cell Disease / Trait	❑ Yes	❑ No	if yes, what type? _____		
Bleeding Disorders	❑ Yes	❑ No	Lung problems	❑ Yes	❑ No
Blood Clotting Disorders	❑ Yes	❑ No	if yes, what type? _____		
Anemia	❑ Yes	❑ No	Mental Illness	❑ Yes	❑ No
Chickenpox	❑ Yes	❑ No	if yes, what type? _____		
Seizures	❑ Yes	❑ No	Cancer	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	if yes, what type? _____		
Gestational Diabetes	❑ Yes	❑ No	Other Chronic Illnesses	❑ Yes	❑ No
Hypothyroidism	❑ Yes	❑ No	if yes, what type? _____		
Hyperthyroidism	❑ Yes	❑ No	Have you ever received the Gardasil® injection?	❑ Yes	❑ No

Last Bone Density Scan _____ / _____ / _____ Last Colonoscopy _____ / _____ / _____

Last Pap Smear _____ / _____ / _____ Last Mammogram _____ / _____ / _____

Past Surgical History (please include colonoscopies, upper GI scopes, breast biopsies, laparoscopic surgeries)

Date	Procedure	Hospital / Facility

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Obstetrical History

Total Pregnancies	Full Term (38+ weeks)	Premature (less than 37 weeks)	Multiples / Twins	Miscarriages	Abortions	Ectopic / Tubal	Living Children

Pregnancy Summary

Date of Delivery	Weeks (ex: 38 weeks)	Hours in labor	Birth Weight	Male / Female	Type of Delivery (Vaginal, C-Section, Vaginal w/ Forceps, Vaginal w/ Vacuum, VBAC)	Anesthesia (Epidural, Spinal, General, None)	Complications (Yes or No)	Facility

If yes to complications, please explain _____

Reproductive History

What age did you start having periods? _____
How many days between your cycles? _____
How many days does your period last? _____
First day of last menstrual period _____
Certainty of date of last menstrual period ❑ Certain ❑ Uncertain
Flow rate ❑ Light ❑ Medium ❑ Heavy
Clots? ❑ Yes ❑ No
Bleeding between periods? ❑ Yes ❑ No
Are you using any type of birth control? ❑ Yes ❑ No
If yes, what type? _____
If menopausal, what age? _____
If menopausal, are you taking hormones? ❑ Yes ❑ No
Have you ever taken hormones? ❑ Yes ❑ No

Social History

Are you currently sexually active? ❑ Yes ❑ No
Do you use tobacco products? ❑ Yes ❑ No ❑ Never ❑ Former
Type: _____ How much: _____
Age started: _____ Age quit: _____
Do you drink alcohol? ❑ Yes ❑ No ❑ Never ❑ Occasionally
How often: _____ Age started: _____
Do you use illicit or "street" drugs? ❑ Yes ❑ No ❑ Never
If yes, what type and how much? _____
Highest level of education completed _____
Do you exercise regularly?
❑ 1 – 3 times per week ❑ 4 – 7 times per week
❑ Active with no formal exercise ❑ None
Do you wear seatbelts? ❑ Yes ❑ No
Have you ever had a blood transfusion? ❑ Yes ❑ No

Family Medical History

			Maternal Relatives	Paternal Relatives
Heart Issues	❑ Yes	❑ No	_____	_____
Stroke	❑ Yes	❑ No	_____	_____
High Blood Pressure	❑ Yes	❑ No	_____	_____
Suicide	❑ Yes	❑ No	_____	_____
Mental Illness	❑ Yes	❑ No	_____	_____
Multiple Births	❑ Yes	❑ No	_____	_____
Birth Defects	❑ Yes	❑ No	_____	_____
Diabetes (if yes, include type)	❑ Yes	❑ No	_____	_____
Cancer (if yes, include type)	❑ Yes	❑ No	_____	_____