ACMH

Armstrong County Memorial Hospital
One Nolte Drive Kittanning, PA 16201-8802

Patient's Name ____________________

Allergies ____________________

Reaction ____________________

OB/GYN
Health History

Women's Health Care
Medical Arts Building, Suite 540
Kittanning, PA 16201

ABC Women's Care
Medical Arts Building, Suite 300
Kittanning, PA 16201

Today's Date __________ Referred By __________ Blood Type __________ Family Doctor __________

Age ______ Race ______ Religion __________ Maiden Name __________ Spouse's Name __________

Home ____________________ Phone ( ) __________

Employment ____________________ Phone ( ) __________

Person to Contact in Emergency __________ Relationship __________ Phone ( ) __________

Pharmacy ____________________ Phone ( ) __________

Medical History

(Check all choices that apply)

- ☐ Never Married
- ☐ Married How Long? ______ No. of times ______
- ☐ Separated How Long? ______
- ☐ Divorced How Long? ______
- ☐ Widowed How Long? ______
- ☐ Living with (circle) Alone Husband Parents Friend Boyfriend Child(ren)

Education

(Circle last year completed)

1 2 3 4 5 6 7 8 9 10 11 12

College 1 2 3 4

Graduate School 1 2 3 4

Last Period Began: __________ DATE

Last Pap Smear: __________ DATE

Last Mammogram: __________ DATE

Family History	Living (✓)	Deceased (✓)	Cause of Death?
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sisters - #			
Brothers - #			

Medical History- Patient

Social	*Yes*	*No*	*Amount*	*Duration*
Smoking	☐	☐	______	______
Alcohol	☐	☐	______	______
Drugs	☐	☐	______	______

If not using drugs now, have you ever used drugs in the past ☐ Yes ☐ No

If yes, indicate type and duration of use: ____________________

Caffeine Intake	*Amount Per Day*
☐ Coffee	______
☐ Tea	______
☐ Pop -	______
☐ Chocolate	______

Health History

Medical History - Patient and Family - (Check only if applicable to you. Indicate family member by: (M) Mother (F) Father, (S) Sister, (B) Brother, (A) Aunt, (U) Uncle, (GM) Grandmother, (GF) Grandfather (C) Child	You (✓)	Family Member	Please Explain in Detail
Heart Disease Type:			
Heart Murmurs / Rheumatic Fever			
High Blood Pressure			
Stroke			
Kidney Disease			
Diabetes			
Cancer Type:			
Lung Problems - asthma, TB, other			
Breast Disease or problems (not Cancer)			
Joint Pains / Arthritis			
Easy Bleeding or Bruising			
Anemia			
Seizure disorder / convulsions			
Migraine headaches			
Thyroid disease			
Lymph node disorders			
Hepatitis / Liver disease			
Gallbladder disease			
Stomach disorders / ulcers			
Intestinal problems - colitis, irritable bowel			
Varicose veins / phlebitis / clots in veins			
Birth defects / inherited disease			
Mental defects / inherited disease			
Recent infections or fever			
Multiple Births			
Other medical problems			

Have you ever been transfused: ☐ Yes ☐ No When? ________ Why? ________

List any unusual childhood diseases: ________

List recent immunizations: ________

Are you or have you been exposed to toxic chemicals? ☐ Yes ☐ No Explain: ________

Medications - (*Include those nonprescription drugs taken frequently.)*

List medications taken routinely			List medications limited to a current illness		
Drug	Dose	Illness	Drug	Dose	Illness

Health History

Medical History - Patient *(continued)*

Hospitalizations

Mo/yr	Illness or Operation	Hosp./Doctor	Complications Yes	No
/			☐	☐
/			☐	☐
/			☐	☐
/			☐	☐
/			☐	☐
/			☐	☐

Sexual History

Sexually Active? ☐ Yes ☐ No

Frequency: ____________ times per ____________

Painful Intercourse: ☐ Yes ☐ No

Have you ever had a sexual partner who:

- ☐ used injectable drugs?
- ☐ had hepatitis?
- ☐ was bisexual?
- ☐ had AIDS?

Family Planning	Presently	In the Past
☐ None	☐	☐
☐ Diaphragm	☐	☐
☐ Condoms	☐	☐
☐ Foam	☐	☐
☐ Condoms & Foam	☐	☐
☐ Rhythm	☐	☐
☐ Pills	☐	☐
☐ IUD	☐	☐
☐ Sterilzation (self or partner)	☐	☐
☐ Depo Pravera	☐	☐
☐ Other	☐	☐

If you are, or have taken birth control pills in the past, list the name or names of those pills: ____________

____

If sterilization has been performed, When? Date ____________ Method? ____________ Female? ☐ Male? ☐

Menstrual History

At what age did you begin having periods? ____________ How many days do you flow? ____________

How many days from the start of one period to the next? ____________

Is the flow ☐ Heavy ☐ Medium ☐ Light? Clotting ☐ Yes ☐ No

Cramps? ☐ Yes ☐ No ☐ Mild ☐ Moderate ☐ Severe?

Are your periods accompanied by: Nausea & Vomiting ☐ ? Diarrhea ☐ ? Light Headedness ☐ ?

Do you bleed more than once a month? ☐ Yes ☐ No If so, ☐ rarely or ☐ often?

Are your periods preceeded by: ☐ sore breasts? ☐ depression? ☐ short temper? ☐ crying? ☐ craving for sweets? ☐ bloating? ☐ fatigue? ☐ feeling ill?

Are your periods accompanied or preceeded by headache? ☐ Yes ☐ No If so, are these headaches ☐ Migraine or ☐ Non-migraine?

How long before your period do you have these symptoms? ____________

How long have you been having these symptoms? ☐ months ☐ years.

Do you ever skip periods? ☐ Yes ☐ No How often? ____________ times per year.

Have you stopped having periods? ☐ Yes ☐ No When? ____________

Do you experience hot flashes? ☐ Yes ☐ No ☐ I have in the past.

Health History

Obstetrical History: ***# of times pregnant*** ______

How many of the above number of pregnancies were born prematurely? ______

How many of the above number of pregnancies were miscarriages? ______

How many of the above number of pregnancies were aborted? ______

How many living children do you have? ______

Deliveries: No.	Born mo/yr	Weight at birth	Baby's sex	Weeks preg.	Type of delivery	Complications Yes	Complications No
1	/	lb. oz.				☐	☐
2	/	lb. oz.				☐	☐
3	/	lb. oz.				☐	☐
4	/	lb. oz.				☐	☐
5	/	lb. oz.				☐	☐

Have any of the female members of your family (mother, sisters, aunts, grandmothers) experienced difficult labors or deliveries? If so, please indicate who and describe: ______

Do you douche on a regular basis? ☐ Yes ☐ No If yes, with what? ______

Gynecological Complaints - Patient

	Yes	No	*In the Past*	*Current*	*If yes, please explain*
Breast Problems	☐	☐	☐	☐	______
Vaginal Discharge	☐	☐	☐	☐	☐ White ☐ Clear ☐ Yellow ☐ Thick ☐ Thin ☐ Itching ☐ Rash ☐ Odor ☐ Burning
Pelvic Pressure	☐	☐	☐	☐	______
Pelvic Pain	☐	☐	☐	☐	______
Pelvic Infections	☐	☐	☐	☐	______
Venereal Diseases	☐	☐	☐	☐	______
Infertility	☐	☐	☐	☐	How long? ______
Urinaty Problems	☐	☐	☐	☐	______
Leaking of Urine	☐	☐	☐	☐	When: ☐ coughing ☐ lifting ☐ sneezing ☐ exercising ☐ laughing ☐ on the way to the bathroom
Bowel Problems	☐	☐	☐	☐	______
Previous Abnormal Pap	☐	☐	☐	☐	Date: ______

State reason for today's visit: ☐ Routine Checkup Only

☐ Other ______