PREMIER WOMEN'S HEALTH, LLC

NAME DATE

AGE MARITAL STATUS OCCUPATION

PATIENT PROFILE

MEDICAL HISTORY

Circle if you have had a history of any of the following:

- Measles/German Measles
- Chicken Pox / Mumps
- Whooping Cough / Diphtheria
- Rheumatic Fever/Scarlet Fever
- Mumps
- Tuberculosis
- Covid 19
- Pneumonia / Bronchitis / Asthma
- Sickle Cell/Sickle Cell Trait
- Diabetes
- Heat Attack / Heart Failure
- High Cholesterol
- High Blood Pressure
- Blood Clotting Disorders
- Deep Vein Thrombosis / Pulmonary Embolism
- Hypothyroid
- Hyperthyroid
- Heart burn/Reflux
- IBS/IBD/Constipation/Diarrhea
- Diverticular Disease
- Crohn's Disease / Ulcerative Colitis
- Stroke/TIA
- Migraines / Seizures
- Depression / Anxiety / Bipolar / Schizophrenia
- Sexually Transmitted Infections
- Cancer

Any other health issues:

_____

_____

_____

Any recent travel outside the US (when/where):

_____

Drug Allergies and what reaction(s):

_____

_____

_____

Current Medications (include medicines/vitamins/supplements/herbs with dosage):

_____

_____

_____

_____(please use back if you need more space)

Surgeries / Procedures:

_____

_____

_____

(CONTINUED)

NAME DATE

Last Pap Smear: Date _____ Results _____ Where_____

Have you ever had an abnormal Pap? ☐ No ☐ Yes If yes, date: _____ Treatment: _____

Mammogram: Date _____ Results _____

Colonoscopy: Date _____ Results _____

DEXA Scan (bone density): Date _____ Results _____

Current Birth Control _____

MENSTRUAL & SEXUAL HISTORY

Are your cycles: light / medium / heavy # tampons/pads on heaviest day:_____ Do you have sex with: men/women/both/none

_____ Age of first menstrual cycle Are your cycles regular? ☐ No ☐ Yes Do you have cramping? ☐ No ☐ Yes

_____ # Days you bleed Do you have clotting? ☐ No ☐ Yes Size of Clots: _____

_____ Age of first intercourse _____ # Current sexual partners _____ # Lifetime sexual partners

PREGNANCIES, MISCARRIAGES & ABORTIONS

	Year	Length of Pregnancy	Hours in Labor	Weight of Baby	M/F	Anesthesia	Complications
1							
2							
3							
4							
5							
6							

Tobacco Use

Smoking _____ Vaping _____ Chewing _____

Alcohol Use

Type _____ Drinks/Wk _____ Frequency: Experimental / Social / Regular Use

Recreational Drug Use: Marijuana / CBD / Cocaine / Heroine / LSD / PCP / Meth / Other: _____

Frequency: Experimental / Social / Regular Use

FAMILY HISTORY

Circle any if your family has a history of any of the following, then specify family member:

Diabetes: _____

Heart Attack: _____

High Blood Pressure: _____

High Cholesterol: _____

Ovarian Cancer: _____

Breast Cancer: _____

Uterine Cancer: _____

Cervical Cancer: _____

Colon Cancer: _____

Thyroid Cancer: _____

Skin Cancer: _____

Heart Attack: _____

Stroke / TIA: _____

Blood Clotting/DVT/PE: _____

Hyperthyroid / Hypothyroid: _____

Alzheimers / Dementia: _____

Seizures: _____

Asthma: _____

Other: _____

_____