921-B Jasonway Ave., Columbus, OH 43214 614.268.8800 (phone) 614.268.8249 (fax)
Professionals for Women's Health

PATIENT INFORMATION

Last Name:

First Name:

Middle Name:

Previous Last Name:

Address:

City: State: Zip:

Date of Birth: SSN: Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race: Ethnicity: Preferred Language:

Employer:

Referring Provider:

Primary Care Physician:

What family members/persons may we talk to about medical concerns?

CONTACT INFORMATION

Home Phone:

PWHealth uses a telephone appointment reminder system.

Work Phone:

Number to call with Reminders:

Mobile Phone:

Email Address:

Please provide the name, relationship to you, and phone number of a person we can contact in an emergency.

Name/ Relationship: Emergency Phone:

INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Package Name:		
Policy Holder:		
Policy Holder DOB:		
Policy Holder SSN:		
Policy Holder Employer:		
Relationship to Patient:		
Policy Holder Employer Phone:		

I agree that the above information is true to the best of my knowledge. I am personally and financially responsible for any incorrect information. I understand that I am to inform my provider of any changes as soon as they occur.

_____ _____

Patient Signature Date

INSTRUCTIONS FOR COMPLETING THE HISTORY FORM

The following questionnaire is used to obtain as much pertinent medical information about possible, so that any factors significant to your health care will be identified. All information is confidential, so please provide answers that are as accurate as possible. Please answer every question or write Not Applicable or Unknown if necessary. After completing the questionnaire, we ask that you bring it with you at the time of your first office visit.
Thank you!

Date: _____ Person Completing Form:

Patient's Name: _____ Signature:

What is your birthdate? _____

What is your occupation? _____

How many years of schooling have you completed? _____

Do you have any pets? Kind: _____

Reason for today's visit? _____

MEDICAL HISTORY

Do you have any religious beliefs that preclude or mandate a certain type of medical therapy? ☐ Yes ☐ No

If yes, explain:

When was your last menstrual period? _____ / ☐ Never

When was your last Pap smear? _____ / ☐ Never

When was your last mammogram? _____ / ☐ Never

Do YOU have a history of:

lung problems?	☐ Yes	☐ No
asthma?	☐ Yes	☐ No
kidney problems?	☐ Yes	☐ No
breast lump or cyst?	☐ Yes	☐ No
abnormal Pap smear?	☐ Yes	☐ No
cancer? (type:)	☐ Yes	☐ No
sexually transmitted disease?	☐ Yes	☐ No
anemia?	☐ Yes	☐ No
heart problems?	☐ Yes	☐ No
high blood pressure?	☐ Yes	☐ No
blood clot in lungs or legs?	☐ Yes	☐ No
diabetes?	☐ Yes	☐ No
seizures?	☐ Yes	☐ No
chicken pox?	☐ Yes	☐ No

Other:

Patient Name:_____ Patient DOB:_____

MISCELLANEOUS

How many cups of caffeinated beverages do you drink per day? (Please check appropriate box.)

☐ Fewer than 3 ☐ 3 to 5 ☐ 6 to 10 ☐ More than 10

How many packs of cigarettes do you smoke per day? (Please check appropriate box.)

☐ None ☐ Less than 1/2 pack ☐ More than 1/2 pack

Do you drink alcohol? (Please check appropriate box.)

☐ Never ☐ Once or less per week ☐ 3 or more times per week

FAMILY HISTORY

Have any family members (excluding husbands) had any of the following disorders?

Heart disease	☐ Yes	☐ No	Relationship	
Diabetes	☐ Yes	☐ No	Relationship	
High blood pressure	☐ Yes	☐ No	Relationship	
Blood or bleeding abnormalities	☐ Yes	☐ No	Relationship	
Cancer (type :)	☐ Yes	☐ No	Relationship	
Birth defects	☐ Yes	☐ No	Relationship	
Kidney abnormalities	☐ Yes	☐ No	Relationship	
Intellectual developmental disorder	☐ Yes	☐ No	Relationship	
Epilepsy	☐ Yes	☐ No	Relationship	
Cerebral palsy	☐ Yes	☐ No	Relationship	
Inherited diseases	☐ Yes	☐ No	Relationship	
Sickle cell diseases	☐ Yes	☐ No	Relationship	
Thyroid disease	☐ Yes	☐ No	Relationship	
Osteoporosis	☐ Yes	☐ No	Relationship	

OBSTETRICAL HISTORY

Please list all of your pregnancies

Pregnancy Number:	1	2	3	4	5	6	7
What month/year was each baby born?							
How much did each baby weigh?							
What sex was each child? (M or F)							
Approximately how long (in hours) was each labor?							
How many months pregnant were you with each delivery (e.g. 9 months etc., or weeks, if known)							
C-section or vaginal delivery? (C or V)							

Have you had:

An abortion?	☐ Yes ☐ No	How many weeks pregnant?	Year			weeks pregnant
		How many weeks pregnant?	Year			weeks pregnant

A miscarriage?	☐ Yes ☐ No	How many weeks pregnant?	Year			weeks pregnant
		How many weeks pregnant?	Year			weeks pregnant

Patient Name:_____ Patient DOB:_____

CURRENT MEDICINES

Are you taking any medicines? ☐ Yes ☐ No If yes, please list name, dosage, and times taken per day for each.

NAME	DOSAGE	TIMES PER DAY

Do you use recreational drugs (cocaine, marijuana, hashish or hard drugs)? ? ☐ Yes ☐ No

ALLERGIES

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list name and reaction to each medicine.

NAME OF MEDICINE	REACTION

SURGERY AND HOSPITALIZATIONS

Have you ever had surgery? ☐ Yes ☐ No If yes, please list place, year and reason.

PLACE	YEAR	REASON

Are you ever been hospitalized? ☐ Yes ☐ No If yes, please list place, year and reason.

PLACE	YEAR	REASON

INJURIES

Have you ever had any major injuries? ☐ Yes ☐ No If yes, please list date and type of injury.

DATE	INJURY

Are you ever had a blood transfusion? ☐ Yes ☐ No If yes, list date: