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:

Work Phone:

Mobile Phone:

PWHealth uses a telephone appointment reminder system.

Number to call with Reminders:

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

Professionals For Women's Health
New Patient History Form

DEMOGRAPHICS

Name: _____ Preferred Name: _____

Preferred pronouns: _____ Birth Date: _____

Ethnicity: _____

Pharmacy Name/Location/Telephone:_____

Primary Care Provider: _____

Occupation: _____

Primary Language: _____

Do you request interpretive services (circle one)? Yes No

MEDICATIONS (Please list ALL medications, including over the counter, supplements & herbs)

Name of Medication	Dose	How many times a day do you take it?

ALLERGIES

Name of Medication	What happens when you take this medication?

MEDICAL HISTORY

Condition	YES	NO	Provider Notes
Anemia			
Anesthetic Complications			
Asthma or lung problems			
Autoimmune Disorder (i.e. lupus)			
Breast problem (i.e. lumps, biopsy, surgery)			
Cancer			
Chicken Pox			
Diabetes or Gestational Diabetes			
Heart Problem (i.e. arrhythmia, disease, surgery)			
Liver Disease (i.e. hepatitis)			
Blood Transfusion			
High blood pressure or Pre-eclampsia			
Infertility			
Kidney or Urinary Problems			
Neurologic (i.e. migraines, seizures)			
Psychiatric or mental health (i.e. anxiety, depression, bipolar)			
Sexually Transmitted Diseases			
Thyroid Problems			
Herpes			
Bleeding or clotting disorders (i.e. factor V or von willebrands)			
Blood clots, DVT, pulmonary embolism			
Other (please specify)			

SURGICAL HISTORY

Type of Surgery	Year of Surgery

SOCIAL HISTORY

Relationship Status (circle all that apply): Married Single Separated Divorced
Same Sex Relationship Monogamous Relationship Other

Do you have any history of abuse, including sexual, physical and emotional? YES NO

Have you ever smoked or used e-cigarettes? YES NO **Current smoker?** YES NO
Age when you started smoking? _____ Packs/Day: _____

Alcohol Intake (circle one): Never Rarely 1-2 drinks per week 3-5 drinks per week 5+ drinks per week
2+ drinks per day

Caffeine Intake (circle one): Never Rarely 1-2 servings per day 3-5 servings per day 5+ servings per day

Exercise Amount (circle one): Never Rarely 1-2 times per week 3-5 times per week 5+ times per week

Drug Use: Never Used in past Occasional 3-5 days per week 5+ days per week Specify type(s):
_____

Calcium Intake (circle one): Never 1 serving per day 2 servings per day 3 servings per day
Calcium Supplement

GYN HISTORY

Ever sexually active? YES NO **Currently sexually active?** YES NO
Sexually active with (circle one): MEN WOMEN BOTH

Current Contraception (circle): Barriers (male/female condoms) Pills Patch Ring Depo Implant IUD
Tubal Essure Vasectomy Other:_____

Have you completed the Gardasil Series (HPV Vaccine)? YES NO UNSURE

Date of Last Period: _____ How often does your period come?_____
How many days do you bleed? _____ Blood loss (circle one): Light Moderate Heavy

Date of last Pap test _____ Any abnormal Pap tests? YES NO
Any surgical procedures on cervix ? YES NO **If yes, type:_____**

Date of last Mammogram (if applicable): _____ Location _____
Have you ever had an abnormal mammogram? YES NO

Date of last Bone Scan (if applicable): _____
Date of last Colonoscopy (if applicable): _____

FAMILY HISTORY

Adopted or Unknown? _____

Medical Condition	Yes	No	Relationship (include only children, siblings, parents, grandparents--please specify maternal or paternal)
Breast Cancer			
Colon Cancer			
Ovarian Cancer			
Uterine Cancer			
Autoimmune Disease			
Clotting Disorder			
Diabetes			
Heart Disease			
Hypertension			
Osteoporosis			
Thyroid Problems			
Genetic Disorder (i.e.- Down Syndrome, Sickle Cell, Thalassemia, Development Disabilities, Cystic Fibrosis)			
Other			

BIRTH HISTORY

Pregnancy Number	1	2	3	4	5	6	7
Month/Year of birth							
Baby's weight							
Length of labor (in hours)							
How many months or weeks pregnant were you?							
Sex of baby (M or F)							
Name of child							
C-section or vaginal delivery? (C or V)							
Complications with birth or pregnancy?							

OTHER PREGNANCIES

	Year(s)	**Weeks of Pregnancy**
Miscarriages		
Abortions		
Ectopic		

Is there any other information you wish to share that has not been addressed on this form?
YES NO
If yes, please specify:

Patient Signature: _____
Date: _____