

Wellesley Women's Care, P.C.  
 2000 Washington Street, Suite 764  
 Newton, MA 02462-1628  
 617-965-7800

Date: \_\_\_\_\_

Last Name:		First Name:		Date of Birth:	Age:
Address:		Home Phone:		Business Phone:	
		Cell:		Email (optional)	
City:	State:	Zip:	Primary Care M.D.:		
Occupation:			Referred by:		
Religion (optional):					
Marital Status: S M W D S			Spouse's / Partner's Name:		

MEDICAL HISTORY				
How Tall Are You?	What is your usual weight?		What is your present weight?	
Check Yes or No	YES	NO	MEDICAL ( office use )	
<b>Do you now, or have you ever had:</b>				
Weight loss or gain? Eating disorders?				
Migraine headaches? Frequent headaches?				
Contact lenses? Visual problems?				
Frequent nose bleeds? Sinusitis?				
Goiter? Thyroid problems?				
Respiratory Disease?				
Frequent cough? Shortness of breath?				
Pneumonia?				
Night sweats? Tuberculosis?				
Asthma? Hay fever?				
Heart Disease?				
Heart murmur? Mitral valve prolapse?				
Rheumatic fever? German Measles? Chicken Pox?				
Chest pain with exertion?				
High blood pressure?				
Gall Bladder Disease?				
Abdominal pain after meals?				
Blood in bowel movements?				
Any change in bowel habits?				
Hemorrhoids?				
Jaundice? Hepatitis? Mononucleosis?				
Diabetes?				
Kidney Disease?				
Blood, Sugar, or Protein in urine?				
Any kidney stones?				
Kidney or bladder infections?				
Painful urination?				
Loss of urine when coughing or sneezing?				
Anemia? Blood disorder?				
Cancer?				
Varicose veins? Phlebitis?				
Epilepsy? Neurological disorder?				
Psychological problems? Depression?				
Skin Diseases?				
Arthritis? Muscular disorders?				
<b>Are you allergic to any medications:</b> If so, which ones?				

<b>Do you take any medications or hormones?</b> If so, which ones?			
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<b>SURGICAL HISTORY</b>			
<b>Check yes or no</b>	<b>YES</b>	<b>NO</b>	<b>SURGICAL( office use )</b>
Have you ever had any surgery? (Tonsillectomy, appendectomy, etc.). If so, what year, hospital, and city?			
1.			
2.			
3.			
4.			
Do you know your Blood Type and RH?			
Have you ever received Rhogam?			
Have you ever received a blood transfusion?			
Have you ever had an anesthesia complication?			
Have you ever had injuries? (Broken bones, auto accident, etc.). If so, what year, hospital, and city?			
1.			
2.			
3.			
4.			

<b>FAMILY HISTORY</b>			
<b>Check yes or no</b>	<b>YES</b>	<b>NO</b>	<b>FAMILY( office use )</b>
Is your mother alive?			
In good health?			
If deceased, cause?			
Is your father alive?			
In good health?			
If deceased, cause?			
Do you have any brothers?			
If yes, how many?			
Do you have any sisters?			
If yes, how many?			
Is your husband / partner in good health?			
In your family (grandparents, parents, and siblings) has anyone had:			
Birth defects?			
High blood pressure?			
Cancer?			
Tuberculosis?			
Diabetes?			
Thyroid Disease?			
Epilepsy?			
Mental illness?			
Twins?			
Blood Disease?			
Stroke?			
Heart Attack?			
Hysterectomy?			
Kidney Disease?			
Is there anything else regarding your medical history, surgical, or family history that you feel we should know?			

<b>SOCIAL HISTORY</b>			
<b>Check yes or no</b>	<b>YES</b>	<b>NO</b>	<b>SOCIAL( office use )</b>
Do you drink coffee? Tea? Cola?			
Do you smoke?			
Do you use alcoholic beverages?			
Do you use street or recreational drugs?			
Have you traveled out of the country in the past two (2 years)?			
Do you desire testing for HIV?			
<b>GYNECOLOGICAL HISTORY</b>			<b>GYNECOLOGICAL( office use )</b>
When did your last period start? Day Month or date of menopause?			
At what age did you first menstruate?			
How many days in your cycle? (ex. 28/30)			
How many days do you flow? (ex. 5/7)			
Is your flow: Light? Average? Heavy?			
<b>Check yes or no</b>	<b>YES</b>	<b>NO</b>	
Do you have any clots?			
Do you have any cramps?			
Do you bleed between periods?			
Do you have excessive vaginal discharge?			
Are you having vaginal itching or irritation?			
Have you had a sexually transmitted disease?			
Do you have any history of Herpes exposure?			
Are you sexually active?			
Are you having any sexual problems?			
Are you using any form of birth control?			
Have you ever had an abnormal PAP?			
Have you had any breast problems?			
Have you had a Mammogram?			
Are you experiencing any Menopausal symptoms?			
Did your mother take Diethylstilbesterol (DES) while pregnant with you?			
Have you ever had any trouble getting pregnant?			
Have you ever had an abortion?			
<b>OBSTETRICAL HISTORY</b>			<b>OBSTETRICAL( office use )</b>
Please list the number of times:			
	Pregnant		
	Premature Births		
	Miscarriages		
	Abortions		
	Living Children		

### PREVIOUS PREGNANCIES

No	Date	Outcome of Pregnancy Vaginal, Cesarean, miscarriage, termination	Weeks Pregnant	Hours in labor	Type Anesth	Total weight gain	Fetal sex	Fetal weight	cond	Breast / Bottle	Place of delivery	Complications / Remarks
1.												
2.												
3.												
4.												
5.												
6.												