PATIENT HISTORY FORM

Name: ______________________________ Age: ________ Date of Birth: ________________

Occupation ______________________________ Single ❒ Married ❒ Divorced ❒ Separated ❒

Family History	Living Age	Living Health	Deceased Age	Deceased Cause
Father				
Mother				
Brother/Sister 1.				
2.				
3.				
4.				
5.				
Husband				
Son/Daughter 1.				
2.				
3.				
4.				
5.				

Any relative ever had:	NO	YES	Who
Cancer	❒	❒	______
Colon ❒ Ovarian ❒ Uterine ❒ Breast ❒			
Tuberculosis	❒	❒	______
Diabetes	❒	❒	______
Heart Trouble	❒	❒	______
High Blood Pressure	❒	❒	______
Stroke	❒	❒	______
Epilepsy	❒	❒	______
Suicide	❒	❒	______
Mental Illness	❒	❒	______
Hysterectomy	❒	❒	______
Cesarean Section	❒	❒	______
Kidney Trouble	❒	❒	______
Other	❒	❒	______

Menstrual History

Age at onset: _______

Regular Yes ❒ No ❒

Cycle __________ days (from start to start)

Usual duration ______ days

Flow Light ❒ Moderate ❒ Heavy ❒

Pains or cramps Yes ❒ No ❒

Date of last period ______________________

Present birth control method ______________

Last pap smear ________________________

List Pregnancies (including miscarriages)

Year	Infant Weight	Sex	Hours of Labor	Anesthesia	Complications

Personal History

Weight: Now ___________ 1 year ago ___________ Highest ___________ When ___________

Have you ever had	No	Yes	Unknown	Remarks
German Measles	❒	❒	❒	
Mumps	❒	❒	❒	
Chicken Pox	❒	❒	❒	
Scarlet Fever	❒	❒	❒	
Diptheria	❒	❒	❒	
Polio or Meningitis	❒	❒	❒	
Pneumonia	❒	❒	❒	
Tuberculosis	❒	❒	❒	
Mononucleosis	❒	❒	❒	
Rheumatic Fever	❒	❒	❒	
Heart Disease	❒	❒	❒	
Heart Murmur	❒	❒	❒	
High or Low Blood Pressure	❒	❒	❒	
Epilepsy/Seizures	❒	❒	❒	
Migraine Headaches	❒	❒	❒	
Cancer	❒	❒	❒	
Yellow Jaundice/Hepatitis	❒	❒	❒	
Asthma	❒	❒	❒	
Bladder/Kidney Infections	❒	❒	❒	
Gallbladder Disease	❒	❒	❒	
Kidney Stones	❒	❒	❒	
Phlebitis	❒	❒	❒	
Nervous Condition/Mental Illness	❒	❒	❒	

PATIENT HISTORY FORM (cont.)

Do you now have or have you ever had	No	Yes	Remarks
Any eye disease, injury, impaired sight	❒	❒	
Any ear disease, injury, impaired sight	❒	❒	
Any trouble with nose, sinuses, mouth, throat	❒	❒	
Any head injury, fainting spells, convulsions	❒	❒	
Frequent or severe headaches	❒	❒	
Skin disease	❒	❒	
Chronic or frequent cough	❒	❒	
Chest pain or spitting up of blood	❒	❒	
Night Sweats	❒	❒	
Shortness of breath	❒	❒	
Swelling of hands, feet, or ankles	❒	❒	
Varicose veins	❒	❒	
Kidney or bladder disease	❒	❒	
Indigestion, stomach trouble or ulcer	❒	❒	
Rectal bleeding, constipation or diarrhea	❒	❒	
Loss of urine with cough or sneeze	❒	❒	

Alcoholic Beverages: ❒ Never ❒ Moderate ❒ Daily Cigarettes _______ packs per day

Surgery – what, when, where

____

____

Drug/Medicine allergies ____

What medicines are you now on: ____

Transfusions: ❒ No ❒ Yes Number ______________________________________

Hospital admissions (other than delivery or surgery)

____

____

____

AUTHORIZATION TO RELEASE INFORMATION

Permission is hereby given to Tifton Woman's Center to furnish information from the record of ______________________________________ to the inquiring insurance company.

Signature ______________________________________ Date ________________

AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby authorize payment to the Physician signing this form, the amount of all benefits for which I may be due for medical service and any other professional service.

Physician Signature ______________________________________ Date ________________