

MEADOWBROOK WOMEN'S CLINIC, P.A.

825 South 8th Street, Suite 1018 Minneapolis, MN 55404 (612) 376-7708

County of Residence _____

Current Employer _____

Occupation _____

What is your religion? _____

Educational Background (highest level **completed** - circle only **one**):

Kindergarten 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Marital Status: (Circle One) Never Married Married Divorced Separated Widowed

Race/Ethnicity: (Circle One) Caucasian African American Native American Hispanic Asian Other _____

How did you hear about our clinic? _____ Who referred you? _____

Who came with you today? _____ How are you getting home? _____

Please check off types of birth control you have used in the past:

_____ Rhythm _____ Birth Control Pill _____ Norplant

_____ Withdrawal _____ Tubal Ligation _____ Other

_____ Douche _____ Vasectomy _____ None

_____ Foam _____ Suppositories

_____ Condom _____ Depo Provera (shot/injection)

_____ Diaphragm _____ Natural Family Planning

_____ IUD _____ Cervical Cap

Were you using a contraceptive method when your pregnancy occurred? _____ What kind? _____

What method of birth control do you plan to use in the future? _____

Do you plan to return here for your check-up? _____ Yes _____ No

Pregnancy History:

_____ Number of live births

_____ Number of abortions

_____ Number of miscarriages

_____ Number of tubal/ectopic pregnancies

_____ Number of premature deliveries

_____ Number of caesarean sections

_____ Number of stillbirths

Date of last delivery _____

Are you breastfeeding now? _____

Any children placed for adoption? _____

Menstrual History:

First day of your last NORMAL period _____

Age when your periods started _____

How often do you get a period? _____

How many days do you bleed with your period? _____

GYN History:

Have you ever had a pelvic or speculum exam? _____

Date of your last Pap Smear _____

Date of your last breast exam _____

PATIENT SELF HISTORY FORM (CURRENT AND PAST). PLEASE CHECK (✓) EITHER THE YES OR NO COLUMN.

Yes	No		Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	Drug or medication allergies	<input type="checkbox"/>	<input type="checkbox"/>
		List: _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Food or other allergies	<input type="checkbox"/>	<input type="checkbox"/>
		List: _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Anemia or low hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur due to Rheumatic Fever, heart surgery, or mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Any joint surgery or artificial joints?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Has your physician advised you to be pre- medicated with antibiotics prior to dental work or any other medical procedures?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, liver disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cigarette use	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal infections	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cysts on ovaries	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Problems with Fallopian Tubes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Problems with uterus	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Pap smears	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations (list) _____	<input type="checkbox"/>	<input type="checkbox"/>

<input type="checkbox"/>	<input type="checkbox"/>	Surgeries (list) _____	<input type="checkbox"/>	<input type="checkbox"/>

Is there any other information that you'd like to share with us? _____

I hereby acknowledge that I have given full and truthful information. I understand that there may be additional risks/complications for lack of disclosure of a full medical history/truthful information.

Signature of Patient _____ **Date** _____

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STAFF NOTES (for office use only)

Reviewed by _____ Date _____