Locust Grove Women's Health
HEALTH HISTORY

Name:_____

Smoking History	Alcohol Consumption/Drug Use	Exercise Habits	Allergies to Medications
[] Never Smoked [] Quit (DATE: _____) [] Current _____ pack/day [] Other Tobacco Use: _____ _____	[] Non-Drinker [] Number of drinks per week: _____ [] Recreational drug use: _____	_____ _____ _____	[] None Known [] List Any _____ _____ _____ _____

CURRENT MEDICATION LIST (Include over-the-counter medications and nutritional supplements)

1.	4.	7.	10.
2.	5.	8.	11.
3.	6.	9.	12.

LONGSTANDING OR ONGOING MEDICAL PROBLEMS

1.	3.	5.	7.
2.	4.	6.	8.

SURGICAL HISTORY (Type and year performed)

1.	3.	5.	7.
2.	4.	6.	8.

FAMILY HISTORY & RISK PROFILE

YOUR RELATIVES' HISTORY	Have you or any of your blood relatives had any of the following conditions?	
Father: [] Alive – Age: _____ [] Deceased at age _____ Cause of death: _____	Check below if "YES"	Describe each "YES" below
Mother: [] Alive – Age: _____ [] Deceased at age _____ Cause of death: _____	[] Cancer or Tumor	
Maternal Grandfather: [] Alive [] Deceased at age _____ Cause of death: _____	[] Heart Attack/Stroke	
Maternal Grandmother: [] Alive [] Deceased at age _____ Cause of death: _____	[] High Blood Pressure	
Paternal Grandfather: [] Alive [] Deceased at age _____ Cause of death: _____	[] Diabetes (Type 1 or 2)	
Paternal Grandmother: [] Alive [] Deceased at age _____ Cause of death: _____	[] Other Heart Disease	
Description of significant health problems in your grandparents:	[] Thyroid Disease	
	[] Lung Disease/COPD	
	[] Anemia	
	[] Bleeding Disorder	
Number of Brothers and Sisters: _____	[] Ulcers or Colon Disease	
Number of Children: _____	[] Kidney Disorder	
Description of significant health problems in siblings / your children:	[] Epilepsy/Convulsions	
	[] Birth Defects	
	[] Mental Illness/Suicide	
	[] Tuberculosis	
	[] Glaucoma	
	[] OTHER	

GYN/Menstrual History:

Age at onset of menstruation: _____
Regular Cycles: Yes ___ No ___
Cycle Frequency: _____ days (from start to start)
Usual Duration: _____ days
Flow: Light ___ Mod ___ Heavy ___
Pains or cramps: Yes No

Date of last Menstrual Cycle: _____
Date of last Pap Smear: _____
Normal ___ Abnormal ___
Any history of abnormal Pap? Yes ___ No ___
If post-menopausal: Natural ___ Hyst ___
Number of pregnancies: _____
Number of live births: