AdventHealth Ottawa

PATIENT HISTORY FORM

1301 S. Main Street, Ottawa, KS 66067
833-RMH-CARE or 785-242-9889

Specializing in Menopause, Contraceptive/Family Planning, Menstrual Abnormalities, Comprehensive Women's Health Care and Gynecological Preventive Care

Hours: Tuesday and Thursday, 8:00 am to 4:30 pm

****Please have this form completed PRIOR to your visit. Co-pays are to be paid on the date of service.**

Date: ________________________

If you are uncomfortable answering any questions, please leave them blank; you can discuss them with the doctor or nurse.

PATIENT INTAKE HISTORY

Last name:	First name:
Birthdate: / /	
Primary Doctor:	Referred by:
What is the reason for today's visit?	
Preferred Pharmacy:	
Please describe your problem, including where it is, how severe, and how long it has lasted:	

GYNECOLOGIC HISTORY

Last normal menstrual period (first day): / /	Age period began:
Length of periods (number of days):	Number of days between periods:
Are you currently sexually active?	Have you ever had sex?
Number of sexual partners (lifetime):	Partners are: ❑ Men ❑ Women ❑ Both
Present method of birth control:	When was your last PAP?
Last Mammogram?	What was the result?
Do you do breast self-examinations?	Have you ever had an abnormal PAP?

OBSTETRIC HISTORY

	Number		Number		Number
Pregnancies:		Abortions:		Miscarriages	
Live Births		Premature Births (weeks?)		Living Children	

Any pregnancy complications?
❑ Diabetes ❑ Hypertension/High Blood Pressure ❑ Preeclampsia/Toxemia ❑ Other

SOCIAL HISTORY

Marital Status: ❑ Single ❑ Married ❑ Long-Term Relationship ❑ Divorced ❑ Widowed

Ever Smoked? ❑Y ❑N	Currently Smoking? ❑Y ❑N	Packs per day:	For how many years?
Drug Use? ❑Y ❑N	If yes, please specify:		
Alcohol? ❑Y ❑N	Drinks per day:	Drinks per week:	
Regular exercise:		How long and how often?	
Dairy product intake and/or calcium supplements:			Daily intake:
Have you ever been sexually abused, threatened, or hurt by anyone?			Do you have a living will?
Number of people in your household?		Highest level of completed schooling?	

PAST HISTORY OF ILLNESSES								
Major Illness	**Mother**	**Father**	**Sister**	**Brothe r**	**Mat Grand Mother**	**Mat Grand Father**	**Pat Grand Mother**	**Pat Grand Father**
Alcohol/Drug Problems								
Alzheimer's								
Anemia								
Arthritis/Cont. Pain/Back Problems								
Asthma								
Autoimmune Disease (Lupus)								
Birth defects								
Bleeding Disorders								
Blood Clots in lungs/legs								
Blood Transfusions								
Bowel Problems:								
Cancer (what kind?)								
Depression/Anxiety								
Diabetes								
Eating Disorder								
Eye Problems								
Fibroids								
Gall Bladder Disease								
Headaches								
Heart Attack/Heart Disease								
Hepatitis/Yellow Jaundice/Liver Disease								
High Blood Pressure								
High Cholesterol								
HIV/AIDS								
Infertility								
Kidney Infections/Stones								
Osteoporosis								
Pneumonia/Lung Disease								
Reflux/Hiatal Hernia/Ulcers								
Rheumatic Fever								
Seizures/Convulsions/Epilepsy								
Sexually Transmitted Disease/Chlamydia								
Stroke								
Thyroid Disease								
Tuberculosis								
Other:								

CURRENT MEDICATIONS
(Please include any over the counter medications and vitamins.)

Drug name	Dosage	Who Prescribed
Any Medication or Latex Allergies? If so, to what?		

OPERATIONS/HOSPITALIZATIONS

Reason	Date	Hospital

REVIEW OF SYMPTOMS

	Now	Past	Explain
CONSITUTIONAL:	❑	❑	
Weight loss/gain; Fever; Fatigue; Change in height	❑	❑	
GASTROINTESTINAL:			
Frequent diarrhea; bloody stool; constipation	❑	❑	
nausea/vomiting/indigestion; involuntary loss of gas/stool	❑	❑	
GENITOURINARY:			
Blood in urine	❑	❑	
Painful urination	❑	❑	
Strong urgency to urinate/frequent urination	❑	❑	
Incomplete emptying	❑	❑	
Involuntary/unintended urine loss	❑	❑	
Urine loss when lifting/coughing	❑	❑	
Abnormal bleeding	❑	❑	
Painful periods	❑	❑	
Premenstrual syndrome (PMS)	❑	❑	
Painful intercourse	❑	❑	
Abnormal Vaginal Discharge	❑	❑	
SKIN:			
Rash; Sores; Dry Skin; Moles (growth/change)	❑	❑	
BREASTS:			
Pain in Breast; Nipple Discharge; Lumps	❑	❑	
PSYCHIATRIC:			
Depression/frequent crying; anxiety	❑	❑	
ENDOCRINE:			
Hair loss; heat/cold intolerance; hot flashes; abnormal thirst	❑	❑	

Form completed by: ❑ Patient ❑ Office ❑ Nurse ❑ Physician ❑ Other ________________________

Signature of Patient: ______________________________________ **Date:** ________________________