Northside
WOMEN'S HEALTH
Dr. Heidi Arbona • Dr. Tammy Chan
Dr. Jodi Bender • Stephanie Beier-Phillips, CNP

550 S. Cleveland Ave.
Suite D
Westerville, OH 43081
614-865-7600
Fax 614-392-2546

Name:________________________________ **Date:**_______________ **Birthdate:**_____________________________

Allergies to Medications:____
____

Medications, Vitamins, and Supplements:____
____
____

Surgeries:____
____
____
____

Your Medical History:

High Blood Pressure
Diabetes
Heart Disease
Stroke
Blood clots in leg or lung
Bleeding disorder
Endometriosis
Asthma
Seizures
Lupus or other joint disease
Depression
Anxiety
Bipolar illness
Anorexia or Bulimia
Irritable bowel syndrome
Chron's disease or Ulcerative Colitis
Breast Cancer
Cancer of the Uterus, Cervix, or Ovary
Colon Cancer
Thyroid disease
Osteoporosis
Other:____________________________
____

Family Medical History/affected relative

High Blood Pressure_____________________
Diabetes_____________________________
Heart Disease__________________________
Stroke_______________________________
Blood Clots in Leg or Lung_______________
Bleeding Disorder_______________________
Endometriosis__________________________
Asthma______________________________
Seizures_____________________________
Lupus_______________________________
Depression___________________________
Anxiety______________________________
Bipolar Illness_________________________
Anorexia_____________________________
IBS_________________________________
Chrons or Ulcerative Colitis_______________
Breast Cancer__________________________
Cancer of the Uterus, Cervix, Ovary________
Colon Cancer__________________________
Thyroid Disease________________________
Osteoporosis___________________________
Other:_______________________________
____

Gynecologic History:

Age of first Menses:______ Frequency of Menses: every ____ days Do you have:Cramping/
Age of Last Menses:______ Duration of Flow: _____________days Clotting/Heavy Flow
Have you ever had an abnormal pap smear? Yes/no
Have you ever had : Colposcopy / Cryotherapy / LEEP / Cone Biopsy / Laser Ablation
Have you ever had: Gonorrhea / Chlamydia / Herpes (oral or genital) / genital warts
What do you use for contraception?____
Have you had any of these Gyn surgeries? Hysterectomy / Removal of Ovaries / Laparoscopy
If you have had a hysterectomy, why did you have the surgery? ___________________________________

↓ **OVER**

Obstetrical History:

Total Number of Pregnancies______Total number of Miscarriages ______ Total Number of Living Children__________

Year: Sex: Weight: Type of Delivery: Delivering Dr: Complications:

Social History:

Single / Widowed / Married / Divorced

Heterosexual / Homosexual / Bisexual

Occupation:_____________________

Tobacco Use (how many cigarettes/day?)_______How many years?____

Alcohol Use (how many drinks/day?)_____________________________

Drug Use:____

Exercise Routine:____

Diet:____