CORNERSTONE
WOMEN'S CARE

Patient Care History – Page One

Patient Name *(First, Last)*

Today's Date

Birth Date

Primary Care Doctor

Allergies

❍ None ❍ Food ❍ Medicine ❍ Other

Specify Allergy

Operations/Hospitalizations *(Specify the Reason and Date of each Operation, Separate Entries with comma)*

Injuries/Hospitalizations *(Specify the Reason and Date of each Operation, Separate Entries with comma)*

Gynecological History

Contraception ❍ Yes ❍ No

Details

History of Abnormal Paps ❍ Yes ❍ No

Details

Sexually Active ❍ Yes ❍ No

Details

Last Menstrual Period *Date*

Details

Personal Past History – Major Illnesses

❍ Asthma	❍ Pneumonia	❍ Chronic Lung Disease
❍ STDs	❍ Rheumatic Fever	❍ Kidney Infections/Stones
❍ Stroke	❍ Bowel Trouble	❍ High Blood Pressure
❍ Diabetes	❍ Glaucoma	❍ Hepatitis/Yellow Jaundice
❍ Ulcers	❍ Thyroid Disease	❍ Heart Trouble/Murmur
❍ Cancer	❍ Tuberculosis	❍ Depression/Anxiety
❍ Fracture	❍ Arthritis/Joint Pain	❍ Anemia/Blood Transfusions
❍ Seizures/ConvulsionsEpilepsy		

Last Immunization or Test	Yes	Date
Tetanus	❍	
Flu Shot	❍	
Pap Smear	❍	
Dexa Scan	❍	
Pneumonia	❍	
TB Skin Test	❍	
Mammogram	❍	
Cholesterol	❍	
Colonoscopy	❍	

Current Medications

Name Dosage

Name Dosage

Name Dosage

Name Dosage

Name Dosage

Name Dosage

Pregnancy History

Births...*Number* Children...*Number*

Abortions...*Number* Miscarriages...*Number*

Pregnancy History Continued

Child One:

Date of Birth _____ *Gestation Age*_____ *Hours of Labor* _____ *Birth Weight* _____ *Sex*_____ *Vaginal* ❍ *C-Section* ❍

Anesthesia _____ *Comments* _____

Child Two:

Date of Birth _____ *Gestation Age*_____ *Hours of Labor* _____ *Birth Weight* _____ *Sex*_____ *Vaginal* ❍ *C-Section* ❍

Anesthesia _____ *Comments* _____

Child Three:

Date of Birth _____ *Gestation Age*_____ *Hours of Labor* _____ *Birth Weight* _____ *Sex*_____ *Vaginal* ❍ *C-Section* ❍

Anesthesia _____ *Comments* _____

Child Four:

Date of Birth _____ *Gestation Age*_____ *Hours of Labor* _____ *Birth Weight* _____ *Sex*_____ *Vaginal* ❍ *C-Section* ❍

Anesthesia _____ *Comments* _____

Family History

	Yes	Relative
Diabetes	❍	_____
Stroke	❍	_____
Heart Disease	❍	_____
High Blood Pressure	❍	_____
Osteoporosis	❍	_____
Drinking Problem	❍	_____
Breast Cancer	❍	_____
Colon Cancer	❍	_____
Ovarian Cancer	❍	_____
Prostate Cancer	❍	_____

Social History

Smoking ❍ Yes ❍ No *Quantity*_____

Details _____

Alcohol ❍ Yes ❍ No *Quantity*_____

Details _____

Drug Use ❍ Yes ❍ No *Quantity*_____

Details _____

Regular Exercise ❍ Yes ❍ No *Quantity*_____

Details _____

Seat Belt Use ❍ Yes ❍ No

Details _____

Patient Personal Profile

Marital Status

❍ Single ❍ Married
❍ Divorced ❍ Widowed

Number of Living Children

_____

Number of People in Household

_____

Current or Most Recent Job

_____

School Completed

❍ High School ❍ Bachelor Degree ❍ Graduate Degree ❍ Other