

WOMEN FIRST OF LOUISVILLE, PLLC
Patient History

We are happy to announce that we are converting your patient record to an electronic medical record this year. Please complete this patient history form and return it to our office **at least two weeks prior** to your visit.

Failure to return this patient history form could result in your appointment being rescheduled.

Fax Number: (502) 891-8752 **Mailing Address:** 3900 Kresge Way, Ste. 30
Louisville, KY 40207
ATTN: Medical Records

Patient Name: _____ **DOB:** _____
Appointment Date: _____ **Physician:** _____

Allergies: Allergic to any medicine Yes No (please circle)

Name of Medication	Reaction (rash, itching, shortness of breath, nausea, etc)
_____	_____
_____	_____

Foods: (please circle) Egg Whites Peanuts Shellfish
Contactants: (please circle) Latex Adhesive Tape Betadine Metal Nickel

Family History: Provide relationship i.e. Mother, Father, Sister, Brother, Grandparent

Negative Family History _____ Adopted, family history unknown _____

Breast Cancer _____ Uterine Cancer _____ Ovarian Cancer _____

Colon Cancer _____ Thyroid Cancer _____ Lung Cancer _____

Other Cancer in Family _____ Kidney Disease _____ Heart Disease _____

Clotting Disorder (DVT, PE) _____ Stroke _____ Diabetes Mellitus _____

High Blood Pressure _____

List all of your medical problems:

List all of your gynecological problems:

Patient Name: _____ **DOB:** _____
Appointment Date: _____ **Physician:** _____

List all of your surgeries:

Primary Care Physician: _____

Social History:

Marital Status _____ most recent occupation _____

Alcohol: Yes No Describe _____ Tobacco: Yes No Describe _____

Pharmacy: _____ Address: _____ Phone# _____

Pregnancy and Birth:

#of Pregnancies _____ # of Vaginal Deliveries _____ # of C-Sections _____ # of Miscarriages _____

of Living Children _____ # of Ectopic Pregnancies _____

Children – Name, birth year, delivering physician IF delivered by Women First Physician

Medications: List any medications and dosage that you are presently taking.

Diagnostic Procedures: Please provide the date of your last:

Bone Density; Dexagram _____

Sahara (heel) _____

Colonoscopy _____

Tetanus Shot _____

Glucose Screen _____

Lipid Profile _____

Mammogram _____

Pap Smear _____

Thyroid Screen _____