

# Women's Lifecycles, PC

Fredericka Heller, MD

530 Kenhorst Blvd., Reading, PA 19611

Telephone 610-775-7133

FAX 610-775-8658

*Obstetrics*

*Gynecology*

**The following information is very important to your health.  
Please take the time to fully and accurately fill out this form**

Name: \_\_\_\_\_ Age \_\_\_\_\_ Today's Date: \_\_\_\_\_

Primary Family Physician: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Previous Gynecologist: \_\_\_\_\_ Pharmacy: \_\_\_\_\_

Medical Problems: \_\_\_\_\_ List all medications (prescription and over-the-counter) you are presently taking:  
(please list) \_\_\_\_\_

Allergy to medications: \_\_\_\_\_

Past surgeries (include year and hospital where performed): \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Referred by: \_\_\_\_\_

**MEDICAL HISTORY** If you have any of the following, please check all that apply:

- |  |   |
|--|---|
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Hypertension     |
| <input type="checkbox"/> Heart murmur              | <input type="checkbox"/> Anemia           |
| <input type="checkbox"/> Phlebitis                 | <input type="checkbox"/> Depression       |
| <input type="checkbox"/> Seizures                  | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Migraines                 | <input type="checkbox"/> Osteoporosis     |
| <input type="checkbox"/> Liver disorders/hepatitis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Gallbladder problems      | <input type="checkbox"/> Diabetes         |

**FAMILY HISTORY:** (Please list which relative.)

Yes	No	
___	___	Breast cancer: _____
___	___	Cancer: Uterus _____ Cervix _____ Ovary _____
___	___	Colon _____ Skin/melanoma _____
___	___	Other cancers: _____
___	___	High blood pressure: _____
___	___	Heart attacks: _____
___	___	Strokes: _____
___	___	Diabetes: _____
___	___	Osteoporosis: _____

**PLEASE COMPLETE OTHER SIDE**

Mother's age or age at death: \_\_\_\_\_ Health problems: \_\_\_\_\_

Father's age or age at death: \_\_\_\_\_ Health problems: \_\_\_\_\_

Medical problems of brothers & sisters: \_\_\_\_\_

Husband's age: \_\_\_\_\_ Health problems: \_\_\_\_\_

Children's ages: \_\_\_\_\_

List any health problems) \_\_\_\_\_

\_\_\_\_\_

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## SOCIAL HISTORY

Yes No  
\_\_\_\_ \_\_\_\_ Do you smoke? How many packs per day? \_\_\_\_\_

\_\_\_\_ \_\_\_\_ Do you drink alcohol? How often? \_\_\_\_\_ What? \_\_\_\_\_

\_\_\_\_ \_\_\_\_ Do you ever used street drugs? Which ones? \_\_\_\_\_

\_\_\_\_ \_\_\_\_ Have you or any of your sexual partners used IV drugs? \_\_\_\_\_

\_\_\_\_ \_\_\_\_ Are you experiencing abuse (currently or in your past)? Physical \_\_\_\_ Sexual \_\_\_\_ Emotional \_\_\_\_

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## GYNECOLOGIC HISTORY

How old were you with your first menstrual period? \_\_\_\_\_

How often do you get periods? \_\_\_\_\_ days

How many days do you bleed? \_\_\_\_\_ Heavy? \_\_\_\_\_ Moderate? \_\_\_\_\_ Light? \_\_\_\_\_

When was the first day of your latest period? \_\_\_\_\_

When was your last pap smear? \_\_\_\_\_ Have you ever had an abnormal pap smear? \_\_\_\_\_ When? \_\_\_\_\_

Yes No  
\_\_\_\_ \_\_\_\_ Have you ever had an infection in your pelvis?

\_\_\_\_ \_\_\_\_ Have you ever had any sexually transmitted diseases (herpes, gonorrhea, genital warts, chlamydia, syphilis)?  
If yes, which ones: \_\_\_\_\_

\_\_\_\_ \_\_\_\_ Do you currently have a sexual partner? Male \_\_\_\_ Female \_\_\_\_ Male & Female \_\_\_\_

\_\_\_\_ \_\_\_\_ Are you having intercourse? \_\_\_\_\_

\_\_\_\_ \_\_\_\_ How many sexual partners have you ever had? \_\_\_\_\_

\_\_\_\_ \_\_\_\_ Were you or your husband sterilized? No \_\_\_\_ Yes \_\_\_\_ Myself \_\_\_\_ Husband

What are you currently using for contraception? (including sterilization)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# OBSTETRICAL HISTORY

List in order all pregnancies, including miscarriages, abortions, stillbirths and live births:

Year	Hospital	Type of Delivery (vaginal, C/Section abortion, miscarriage)	Baby's Weight, Sex, Problems	Breast or Bottle Fed
1)				
2)				
3)				
4)				
5)				
6)				

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Yes	No	Blood type: _____
___	___	Have you had Rubella or MMR vaccine? If yes, what year?
___	___	Do you examine your breasts?
___	___	Have you ever had a mammogram? When: _____ Where: _____
		Normal: _____ Abnormal: _____

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How did you hear about our practice? \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

\_\_\_\_\_

(If anything other than routine annual gynecologic exam, does your referral form indicate these same reasons/problems?)

\_\_\_\_\_

\_\_\_\_\_

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform necessary services I may need.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician/Nurse Practitioner \_\_\_\_\_ Date \_\_\_\_\_  
signature upon review