WOMEN FIRST OF LOUISVILLE, PLLC
Patient History

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_____ Specify type of cancer _____

Clotting Disorder (DVT, PE) _____ Kidney Disease _____Heart Disease_____

Stroke_____ Diabetes Mellitus _____High Blood Pressure_____

List all of your medical problems:

_____

_____

_____

_____

List all of your gynecological problems:

_____

_____

CONTINUED……

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

List all of your surgeries:

_____

_____

Primary Care Physician: _____

Social History:

Marital Status: _____ Most recent occupation: _____

Tobacco (please check one) : Smoker _____ Former smoker _____ Never smoker _____

Current every day smoker _____ Current some day smoker _____

Alcohol: Yes _____ No _____ Describe _____ Preferred language: _____

Pharmacy: _____ Address: _____ Phone# _____

Mail Order 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, including vitamins and over the counter medications, that you are presently taking.

_____ _____

_____ _____

_____ _____

Diagnostic Procedures: Please provide the date of your last:

Bone Density; Dexagram_____

Colonoscopy _____

Glucose Screen_____

Mammogram_____

Thyroid Screen_____

Tdap (Tetanus, Diptheria, Pertussis) _____

Tetanus Shot_____

Lipid Profile_____

Pap Smear_____