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:

_____
_____

CONTINUED……

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_____