

Piedmont HealthCare Women's Center
1804 Davie Avenue Statesville NC 28677 phone (704) 873-7250 Fax (704) 878-9457

Name _____ Age _____ Date _____

Cell phone: _____ Email: _____ Pharmacy: _____

Primary Care Physician _____ Your Occupation: _____

How did you hear about the office? _____

What is the main reason for your visit today? _____

Is anyone accompanying you for your visit? _____

PAST SURGICAL HISTORY

Have you ever had the follow surgeries?

Tonsils _____ Yes _____ No _____ Date _____

Gallbladder _____ Yes _____ No _____ Date _____

Appendix _____ Yes _____ No _____ Date _____

Breast _____ Yes _____ No _____ Date _____

Tubal ligation (tubes tied) _____ Yes _____ No _____ Date _____

Hysterectomy _____ Yes _____ No _____ Date _____

Bladder repair _____ Yes _____ No _____ Date _____

C-Section _____ Yes _____ No _____ Date _____

Other (please list) _____

Have you ever had any complications with surgery?

_____ Yes _____ No. If yes, What? _____

Have you ever had a blood transfusion? _____ Yes _____ No

Have you ever been hospitalized for anything other than childbirth or surgery? _____ Yes _____ No.

Why? _____

ACTIVE PROBLEMS

Do you have any of the following?

High Blood Pressure _____ Yes _____ No

Diabetes _____ Yes _____ No

Depression _____ Yes _____ No

Heart disease _____ Yes _____ No

Others please list _____

ALLERGIES

Please list any medications you may be allergic to (please include reaction)

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Do you have a Latex Allergy? _____

FAMILY HISTORY

List any blood relatives who has ever had any of the following:
 Please be specific (ex. Mother, Father, Siblings only)

High Blood pressure _____ Yes _____ No Relation _____

Diabetes _____ Yes _____ No Relation _____

Heart Disease _____ Yes _____ No Relation _____

Stroke _____ Yes _____ No Relation _____

Breast Cancer _____ Yes _____ No Relation _____

Uterine Cancer _____ Yes _____ No Relation _____

Ovarian Cancer _____ Yes _____ No Relation _____

Colon Cancer _____ Yes _____ No Relation _____

Osteoporosis _____ Yes _____ No Relation _____

Others please list _____

PERSONAL HISTORY

Do you smoke cigarettes ___ Yes ___ No If yes, packs per days _____

Do you drink alcohol? _____ Yes _____ No If yes what type and how often? _____

Do you use street drugs? _____ Yes _____ No If yes what type and how often? _____

Do you have any HIV risk? _____ Yes _____ No. What _____

Marital Status: _____ Single _____ Married
 _____ Widowed _____ Divorced _____ Separated