whc women's health clinic

MEDICAL HISTORY

To provide you with the best care possible we need you to answer the following questions:

Do you have any allergies?_____

Do you have any of the following conditions?

Bleeding/Clotting problems	☐ No	☐ Yes	_____
Diabetes	☐ No	☐ Yes	_____
Migraine/Bad headaches	☐ No	☐ Yes	_____
Asthma	☐ No	☐ Yes	_____
Heart Disease/Murmur	☐ No	☐ Yes	_____
High Blood Pressure	☐ No	☐ Yes	_____
Stomach Problems/ Ulcers	☐ No	☐ Yes	_____

Any other health concerns?_____

1. Have you ever had a pap smear/pelvic exam done before?
   ☐ No ☐ Yes Date of last pap or exam:_____

2. Have you had any bleeding, clots or cramping with this pregnancy?
   ☐ No ☐ Yes

3. Have you experienced severe nausea or vomiting with this pregnancy?
   ☐ No ☐ Yes

4. Are you breastfeeding now?
   ☐ No ☐ Yes

5. Do you have any ongoing infections? *(ie HIV, Hepatitis, MRSA)*
   ☐ No ☐ Yes

6. Have you ever had an infection in your uterus that required antibiotics?
   ☐ No ☐ Yes

7. Have you ever had a sexually transmitted infection?
   ☐ No ☐ Yes If so, when?_____

(Continued)

8. Have you or any close relative had a blood clot in your leg, thigh, lung or pelvis?
   ☐ No ☐ Yes

9. Do you smoke?
   ☐ No ☐ Yes

10. Do you take any medications daily?
   ☐ No ☐ Yes

   If so, have you taken your medications today and what are they?_____

   _____

11. Please list any non prescription or street drugs, herbs or alcohol you have taken in the past 24 hours and the amount you used:_____

   _____

12. Did you eat today?
   ☐ No ☐ Yes If so, when?_____

13. Did you drink today?
   ☐ No ☐ Yes If so, when?_____

14. Do you want to know if this is a multiple pregnancy (twins)?
   ☐ No ☐ Yes

RN: _____

MD: _____