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

OVER