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