## WELCOME to Women's OB/GYN Health and Wellness Center

NAME:		DOB:	AGE:		PRIMARY	CARE MD: _		Date:
YOUR HEA	ALTH HISTORY:	No	Yes					
Asthma								
Cancer-Ty	pe							
Diabetes								
-	d Pressure							
High Chol								
	ia/Lung Disease							
Thyroid Pi	roblems							
Hepatitis								
Stomach/Bowel Disease								
Bladder Infections/Kidney Disease								
Blood Transfusions/Anemia								
Migraines/Headaches								
Psychiatric Problems/Depression								
Other Illness								
GYNECOL	OGIC HEALTH							
Breast Pro	blems							
Abnormal Pap Smears								
Pelvic Inflammatory Disease								
	onorrhea, Chlamydia							
Venereal \	Warts, HPV							
Other								
	IONS: list all meds and doses:							
HERBS &	VITAMINS:							
PREGNAN	ICIES: # of Pregnancies:	# of Children_	Mis	scarriage	s			
					Γ	T		T
Year	Vaginal or Cesarean	Hours of L	abor	Sex	Weight	Name		Complications
	J HAD ANY SURGERIES?				00115:::	ATIONS		
YEAR	OPERATION				COMPLICATIONS			
FAMILY H	ISTORY- Please list affected r	elative			Ova	arian Cancer	П	
Stroke								
Heart Dise			Colon Cancer					
	d Pressure				Other Cancer			
Breast Car						er Disease		