3203 Middle Road, Columbus, IN 47203
Telephone: 812-373-2700

Electronic Medical Record History — Female

Patient Name: ______________________ DOB: ____________

Date: ____________

Drug Allergies

Product Name ____________________ Reaction ____________________

Product Name ____________________ Reaction ____________________

Allergies Other

Are you allergic to:			Further Information
Iodine	☐ Yes	☐ No	
Latex	☐ Yes	☐ No	
Food	☐ Yes	☐ No	
Chemical	☐ Yes	☐ No	
Anesthetic	☐ Yes	☐ No	
Other	☐ Yes	☐ No	

Past History

Have you had:	If so, please describe:
Infection History	
Past Illnesses	
Chronic Diseases	
Accidents	

Surgical Operations

Type of Surgery	Date of Surgery	Reason for Surgery	Name of Surgeon	Name of Facility

Hospitalizations

1. Hospital Name and Location ____________________ Date Admitted ____________

   Reason for Admission ____________________

2. Hospital Name and Location ____________________ Date Admitted ____________

   Reason for Admission ____________________

Patient Name: ______________________ DOB: ______________

Gynecologic/Obstetric History

MENSTRUATION INFORMATION

Age Menstrual Periods Began

Last Menstrual Period Date Actual

Last Menstrual Period Approximate

Menses Duration

Frequency

Regularity

DIAGNOSTIC TEST INFORMATION

Gyn Problem with Diagnostic Tests

Date of Last Pap Smear

Abnormal Pap?

Date of Abnormal Pap?

Type of Abnormal Pap?

SEXUAL INFORMATION

Number of Sexual Partners

Age of First Sexual Encounter

Sexually Transmitted Disease?

CONTRACEPTIVE AND REPROD INFORMATION

Birth Control Method

Hormone Replacement Therapy

Over the Counter / Herbal Remedies Used

How many times have you been pregnant?

How many children do you have?

Have you had any abortions performed?

Have you had spontaneous abortions?

Number of living children

Pregnancy complications

COMMENTS

FAMILY HISTORY

FAMILY MEMBER	AGE	HISTORY

SOCIAL HISTORY

Alcohol Use

Smoking

Diet

Lifestyle/Recent Changes

Exercise

Education

Occupation

Street Drug Use

Seat Belt Use

Sexual Activity

Residence

Place of Birth

Job Description

Hours Worked

Spouse’s Occupation

Off The Record

Patient Name: ______________________________ DOB: ______________

Review of Systems — List any problems

General	
Skin	
Eyes	
Ears	
Nose	
Mouth/Throat	
Neck	
Lungs	
Breast	
Heart	
Stomach	
Urinary	
Female Organs	
Musculoskeletal	
Neurological	
Endocrine	
Blood	
Psychiatric	

Health Maintenance History

CLINICAL INFORMATION	DATE OF TEST / PROCEDURE	NOTES
Pneumovax		
TB Test		
Tetanus Vaccine		
Breast Self-Exam		
Chemistry Panel		
Chest X-Ray		
Cholesterol Test		
Colonoscopy		
Bone Density		
Digital Rectal Exam		
Eye Exam		
ECG (Baseline)		
Female Pelvic Exam		
Hearing Test		
Mammogram		
Pap Smear		
Pulmonary Function Test		
Physical Exam		
Seat Belts		
Stool Occult Blood Test		
Stop Smoking		
Urinalysis		