

## IWC Past Medical History Form

PATIENT INFORMATION:

DATE: \_\_\_\_\_

LAST NAME: \_\_\_\_\_

FIRST: \_\_\_\_\_ MI: \_\_\_\_\_

DOB: \_\_\_\_\_

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ALLERGIES: (medication and type of reaction)

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MEDICINES: (medicine, dosage, frequency)

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ILLNESSES/HOSPITALIZATIONS:

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SURGERIES: (year, type, place, physician)

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FAMILY HISTORY: (mother, father, siblings, grandparents, other)

GYNECOLOGIC HISTORY:

AGE 1<sup>ST</sup> PERIOD \_\_\_\_\_

ABNORMAL PAP SMEAR \_\_\_\_\_

If so, what treatment was administered?

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SEXUALLY TRANSMITTED DISEASES:

Chlamydia     Gonorrhea     Syphilis     Herpes     HPV/Warts

PERIOD

Every \_\_\_\_\_ days, and lasts \_\_\_\_\_ days

Flow:            LIGHT    MEDIUM    HEAVY

Sexual Partners    MALE    FEMALE    BOTH

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OBSTETRICAL HISTORY:

NUMBER OF:

Pregnancies    \_\_\_\_\_

Abortions:      \_\_\_\_\_

Miscarriages:    \_\_\_\_\_

Deliveries:     \_\_\_\_\_

PERSONAL HISTORY:

MARITAL STATUS

Married    \_\_\_\_\_

Single      \_\_\_\_\_

Divorced    \_\_\_\_\_

Widowed    \_\_\_\_\_

Employment: \_\_\_\_\_

Education:    \_\_\_\_\_

Tobacco Use: \_\_\_\_\_

Alcohol Use:  \_\_\_\_\_

Drug Use:     \_\_\_\_\_

I have read and understood all of the above and have given truthful information to the best of my knowledge. By submitting this online form I authorize my signature under proxy until formal documents can be signed upon my visit. I understand that at no point will the contents of this form be submitted to third parties and contents will be treated under laws regarding Patient/Doctor confidentiality.

Signed \_\_\_\_\_ Dated \_\_\_\_\_