Chapin Women's Care
A Lexington Medical Center Physician Practice
557 Columbia Avenue, Chapin, SC 29036
(803) 345-7546 • FAX: (803) 345-7560
Lexington Medical Center

Patient Information

Date: _____

Name: _____ DOB: _____ Age: _____

ALLERGIES: _____

_____

MEDICATIONS: _____

_____

_____

MEDICAL & FAMILY HISTORY (Check all that apply)

FAMILY	YOU	
_____	_____	High Cholesterol
_____	_____	Heart Disease (Heart Attacks or Failure)
_____	_____	Heart Murmur
_____	_____	High Blood Pressure
_____	_____	Diabetes
_____	_____	Thyroid Problems
_____	_____	Anemia or Blood Disorders
_____	_____	Deep Vein Clots or Lung Clots
_____	_____	Stroke
_____	_____	Autoimmune Disease (Ex. Lupus)
_____	_____	Liver or Gallbladder Disease
_____	_____	Stomach or Bowel Disease
_____	_____	Kidney or Bladder Disease
_____	_____	Inherited Disorder or Birth Defect
_____	_____	Asthma
_____	_____	Migraines or Other Headaches
_____	_____	Hepatitis or HIV
_____	_____	Osteoporosis or Osteopenia
_____	_____	Cancer
_____	_____	Other Medical Problems
	_____	Sexual or Physical Abuse
	_____	Blood Transfusion
	_____	Environmental Allergies

SURGICAL HISTORY (List all operations and procedures)

_____
_____
_____
_____
_____
_____
_____
_____
_____

HOSPITALIZATIONS

_____
_____
_____
_____
_____
_____
_____

MENSTRUAL HISTORY: Age at first period: _____ Cycle Length: _____ Length of bleeding: _____

Cramps? ☐ Yes ☐ No Heavy Bleeding? ☐ Yes ☐ No Spotting or Bleeding between periods? ☐ Yes ☐ No

CONTRACEPTIVE HISTORY: (Check all that apply)

☐ Birth control pill or patches ☐ Depo Provera shot ☐ IUD ☐ Diaphragm ☐ Condoms ☐ Tubal Ligation ☐ Vasectomy (Partner)

☐ Other _____ Are you sexually active? ☐ Yes ☐ No Have you had more than 5 partners? ☐ Yes ☐ No

PELVIC INFECTION HISTORY: (Check all that apply)

☐ Yeast Infections ☐ UTI's ☐ Herpes ☐ Gonorrhea ☐ Chlamydia ☐ Syphilis ☐ "PID" ☐ Genital Warts ☐ Trichamoniasis

PAP SMEAR HISTORY: Any Abnormal Pap smears? ☐ Yes ☐ No If so, when? _____

Have you ever had a colposcopy? ☐ Yes ☐ No Any cervical procedures such as a leep, cryotherapy, laser therapy or TCA application? ☐ Yes ☐ No

OBSTETRIC HISTORY: Number of pregnancies: _____ Number of deliveries: _____ Number of living children: _____

Number of adopted or step children: _____ Number of miscarriages or abortions: _____

YEAR	WEIGHT	WEEKS PREGNANT	HOURS IN LABOR	DELIVERY TYPE	COMPLICATIONS
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

SOCIAL HISTORY: Do you exercise? ☐ Yes ☐ No Daily caffeine use: _____ Do you drink alcohol? ☐ Yes ☐ No If so, how often? _____

Do you use any other drugs? ☐ Yes ☐ No Tobacco? ☐ Yes ☐ No How many cigarettes daily or weekly? _____