



KITTITAS VALLEY COMMUNITY HOSPITAL

PATIENT HISTORY

DATE:

PERSONAL PROFILE						
NAME:		NAME YOU WOULD LIKE US TO USE:				
AGE:		OCCUPATION:				
MARITAL STATUS:		PRIMARY CARE PHYSICIAN:				
GYNECOLOGIC HISTORY						
ARE YOU CURRENTLY PREGNANT?						
CURRENT BIRTH CONTROL:						
LAST MENSTRUAL PERIOD (FIRST DAY):						
AGE PERIODS BEGAN:						
NUMBERS OF DAYS BLEEDING:						
NUMBER OF DAYS BETWEEN PERIODS:						
ANY RECENT CHANGES IN PERIODS?						
LAST PAP SMEAR:		RESULTS:				
ABNORMAL PAP IN THE PAST? <u> </u> NO <u> </u> YES (DATE) <u> </u>						
LAST MAMMOGRAM:						
ABNORMAL MAMMOGRAMS/BREAST BIOPSIES IN THE PAST? <u> </u> NO <u> </u> YES (DATE) <u> </u>						
LAST COLONOSCOPY:			RESULTS:			
LAST BONE DENSITY SCAN:			RESULTS:			
ARE YOU CURRENTLY SEXUALLY ACTIVE?						
PHARMACY PREFERENCE:						
OBSTETRIC HISTORY						
	NUMBER		NUMBER		NUMBER	
TOTAL PREGNANCIES		PREMATURE (<37 WKS)		LIVING CHILDREN		
FULL TERM (37-42 WKS)		ABORTIONS		MISCARRIAGES		
PLEASE LIST EACH PREGNANCY BELOW						
NO.	DATE	WEIGHT	SEX	WEEKS PREGNANT	COMPLICATIONS	TYPE OF DELIVERY
1						
2						
3						
4						
5						
CURRENT MEDICATIONS						
	DRUG NAME	DOSE		DRUG NAME	DOSE	
1			5			
2			6			
3			7			
4			8			
MEDICATION ALLERGIES:						

SOCIAL HISTORY

CIGARETTES NEVER CURRENT PAST PACKS PER DAY YEARS

ALCOHOL NONE #DRINKS PER DAY #DRINKS PER WEEK

RECREATIONAL DRUGS (DESCRIBE) CURRENT PAST

HAVE YOU BEEN SEXUALLY ABUSED, THREATENED OR HURT BY ANYONE?
 NO YES

PERSONAL PAST MEDICAL HISTORY

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS? (PAST OR CURRENT)

	YES	NO	DETAILS (DATE/ DESCRIPTION)
ASTHMA			
LUNG DISEASE/ PNEUMONIA			
HEART ATTACK/ANGINA			
DIABETES			
HIGH BLOOD PRESSURE			
STROKE			
BLOOD CLOTS IN LEGS OR LUNGS			
LUPUS/ COLLAGEN VASCULAR DISEASE			
CANCER			
ANEMIA			
BLOOD TRANSFUSION			
HEPATITIS/ LIVER DISEASE			
REFLUX/ STOMACH ULCER			
BOWEL PROBLEMS			
ARTHRITIS/ JOINT PROBLEMS			
GLAUCOMA			
MIGRAINES			
SEIZURES			
RECURRENT BLADDER INFECTIONS			
KIDNEY INFECTION/ STONES			
HERPES			
HIV/ AIDS			
OTHER SEXUALLY TRANSMITTED DISEASES			

CONDITION (CONTINUED)	YES	NO	DETAILS (DATE/DESCRIPTION)
INFERTILITY			
ENDOMETRIOSIS			
UTERINE FIBROIDS			
ABNORMALLY PAINFUL PERIODS			
ABNORMAL VAGINAL BLEEDING			
ABNORMAL VAGINAL DISCHARGE			
LUMPS IN BREASTS			
INVOLUNTARY LOSS OF URINE			
INVOLUNTARY LOSS OF STOOL			
ABNORMAL HAIR GROWTH			
HAIR LOSS			
UNEXPLAINED WEIGHT LOSS / GAIN			
THYROID DISEASE			
MENOPAUSE SYMPTOMS			
DEPRESSION/ ANXIETY			
SUBSTANCE ABUSE			
OPERATIONS			
PROCEDURE/REASON HOSPITALIZED	DATE	HOSPITAL	COMPLICATIONS
1			
2			
3			
4			
5			
6			
INJURIES/ ILLNESSES/ HOSPITALIZATIONS			
DATE	INJURY/ ILLNESS		
1			
2			
3			
4			
5			

FAMILY HISTORY		
MOTHER ____ LIVING ____ DECEASED- AGE/CAUSE OF DEATH		
FATHER ____ LIVING ____ DECEASED- AGE/CAUSE OF DEATH		
SIBLING ____ #LIVING ____ #DECEASED- AGE/CAUSE OF DEATH		
CHILDREN ____ #LIVING ____ #DECEASED- AGE/CAUSE OF DEATH		
ILLNESS	YES	WHICH RELATIVES/AGE OF ONSET
DIABETES		
STROKE		
HEART DISEASE		
BLOOD CLOTS IN LEG OR LUNGS		
HIGH BLOOD PRESSURE		
HIGH CHOLESTEROL		
BIRTH DEFECTS		
SICKLE CELL DISEASE		
OVARIAN CANCER		
COLON CANCER		
UTERINE CANCER		
BREAST CANCER		
OTHER FAMILY HISTORY		

PATIENT SIGNATURE:

DATE REVIEWD BY PHYSICIAN: **PHYSICIAN SIGNATURE:**

ANNUAL REVIEW DATE: **PHYSICIAN SIGNATURE:**

DATE:

DATE:

DATE: