Pali Women's
HEALTH CENTER
642 Ulukahiki St. # 305
Kailua, HI 96734

Today's Date: _____

Name: _____

Date of Birth: _____

PATIENT HISTORY FORM

Marital Status: _____ Occupation: _____Primary Care Physician: _____

Reason for Today's Visit: _____

Current List of Medications: _____

_____

List any health conditions (ex: Diabetes, high blood pressure): _____

_____

Allergies to drugs/medications/x-ray dye/latex: _____

Last Menstrual Period: _____ Are your periods Light, Normal, or Heavy? (please circle)

How often are your periods? every 28 days/ every 20-25 days/ every 35-40 days/ irregular?(please circle)

How long do your periods last? 1-3 days / 3-5 days / 5-7 days / more than 7 days? (please circle)

Do you have cramping with your periods? No or Yes. If yes: Mild, Moderate, Severe (please circle)

Are you currently sexually active: Yes or No (please circle) Birth control method:_____

Last pap smear: _____ Do you have a history of abnormal pap smears? Yes or No

Last Mammogram: _____Last Bone Density: _____ Last Colonoscopy: _____

Pregnancy History:

Year	Male/Female	Weight	Vaginal/C-section	Complications
1.				
2.				
3.				
4.				

Surgical History:

Date	Type of Surgery	Doctor	Hospital
1.			
2.			
3.			
4.			

Family History:

Any relevant family history (ex: cancer, diabetes, hypertension)? If so, who and what kind:_____

_____

Do you smoke cigarettes? If so how much per day: _____

Do you drink alcohol? If so how many drinks per week: _____

Any recreational drug use? Yes or No (please circle)

Do you exercise? If so how many times per week: _____