BARRINGTON HEALTH CARE FOR WOMEN

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BARRINGTON, ILLINOIS 60010
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Patient's Name: ______________________________ Date: ______________

Chart # ______________ What do you want us to call you ______________________ DOB: ______________

Family History	Year of Birth	Living Health	Deceased Age	Cause	Has any relative had	NO	YES	Who
Father					Cancer -	☐	☐	
Mother					Breast or Ovarian	☐	☐	
Brother or Sister 1					Tuberculosis	☐	☐	
2					Diabetes	☐	☐	
3					Heart Trouble	☐	☐	
4					High Blood Pressure	☐	☐	
Husband					Stroke	☐	☐	
Son or Daughter 1					Epilepsy	☐	☐	
2					Mental Illness/Suicide	☐	☐	
3					Hysterectomy	☐	☐	
4					Blood Clots	☐	☐	
5					Kidney Disease	☐	☐	

Menstrual History

Age at onset ______________

Regular ☐ Yes ☐ No

Cycle ______ days (from start to start)

Usual duration _______ days

Flow ☐ Light ☐ Moderate ☐ Heavy

Pain or Cramps ☐ Yes ☐ No

Date of Last Period ____________________

Infants - List Pregnancies (Include Miscarriages)

Year	Weight	Sex	Type of Delivery	Anesthesia	Complications

Personal History

Height ______________ Weight ______________ Highest Weight ______________ When ______________

Have You Ever Had or Currently Have?	NO	YES
German Measles	☐	☐
Mumps	☐	☐
Chicken Pox	☐	☐
Heart Disease	☐	☐
Mitral Valve Prolapse	☐	☐
Heart Attack	☐	☐
Congestive Heart Failure	☐	☐
High Blood Pressure	☐	☐
Lung Disease	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐
Kidney/Bladder Problems	☐	☐
Infection	☐	☐
Incontinence (Leak Urine)	☐	☐
Stomach/Intestinal Problems	☐	☐
Colon/Rectal Problems	☐	☐
Constipation/Diarrhea	☐	☐
Blood in Stools	☐	☐
Liver/Pancreatic Disease	☐	☐
Hepatitis/Jaundice	☐	☐
Diabetes	☐	☐
Cancer	☐	☐
What Type ________		
Anemia	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Eye Disease	☐	☐
Ear, Nose, Throat Disease	☐	☐
Neurological Problems	☐	☐
Epilepsy	☐	☐
Headaches-Chronic	☐	☐
Mental Illness/Depression	☐	☐

Method of Contraception ________

List of Medications/Herbs/Vitamins ________

____

____

____

____

____

Other Problems ________

Cigarettes ________ /day

Alcoholic Beverages ☐ Never ☐ Occasional ☐ Frequent

Street Drugs (History of Use) ________

Blood Transfusion ☐ No ☐ Yes Date ________

Allergies to Medication ________

Other Allergies: ________

Last Pap Smear ________ Last Mammogram ________

Gynecological History	NO	YES
Infertility	☐	☐
Abnormal Pap	☐	☐
When/Treatment	☐	☐
Chlamydia	☐	☐
Condyloma (Warts)	☐	☐
Gonorrhea	☐	☐
Herpes	☐	☐
Syphilis	☐	☐
AIDS/HIV Positive	☐	☐
With Pregnancy:		
Toxemia	☐	☐
Diabetes	☐	☐
High Blood Pressure	☐	☐
Preterm Labor	☐	☐
Birth Defects	☐	☐
Genetic Problems	☐	☐
Multiple Births (Twins)	☐	☐

Surgeries:

Hysterectomy:

Abdominal ________

Vaginal ________

Ovary(s) Removed ________

Laparoscopy ________

Tubal ________

D&C ________

C-Section ________

Other ________

____

For Physician Use Only

History Reviewed:

Date:	Initials:
Date:	Initials:
Date:	Initials:
Date:	Initials:
Date:	Initials: