WOODWARD & ASSOCIATES, P.C

Initial Patient History

www.woodwardassociates.com

Name:	Date of Birth:	SS#:
Address:		
City:	State:	Zip Code:
Home phone:	Cell:	Work:
Email address:		
Occupation:	Referred By:	
Spouse's Name & Date of Birth:	Spouse's Occupation:	

Menstrual History

Date of last period:	Date of period prior to that:	Age of first menses:
Are periods regular? Yes/No	How often do the occur?	How long? _____days
Flow: Light/Medium/Heavy (please circle one)		Any cramping with menses? Yes/No

Obstetrical History

Number of pregnancies:	Number of living children:	Stillbirths:
Number of tubal pregnancies:	Number of miscarriages:	Neonatal deaths:

Last pap smear (date): _____ ***Results:*** _____

Current method of contraception: _____

Allergies/Medications

Are you allergic to any medications? If so, which medications? _____

Any other allergies? (seasonal, food, etc) _____

Medications

Please provide all current medications (including OTC, vitamins, etc)

(Please attach a list of your medications, if you cannot fit them into the table below)

MEDICATION NAME	DOSAGE	HOW OFTEN YOU TAKE THEM

Surgical History

Please list any surgeries you've had & the date performed

Signature: _____ ***Date:*** _____