CWC ✧ NOVA

Comprehensive Patient History

Name: ______________________
Date of Birth: ______________________
Today's Date: ______________________

Past Medical History

Abnormal Pap Smear	yes	no	Clotting Disorders	yes	no	Hypertension	yes	no
Anxiety	yes	no	Colon Cancer	yes	no	Asthma	yes	no
Arthritis	yes	no	Diabetes	yes	no	Thyroid Disorders	yes	no
Autoimmune Disorders	yes	no	Genetic Disorders	yes	no	Ovarian Cancer	yes	no
Breast Cancer	yes	no	GI Disorders	yes	no	Pulmonary Embolism	yes	no
Cardiovascular Disease	yes	no	High Cholesterol	yes	no	Stroke	yes	no

Details: ______________________

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Past Surgeries and Hospitalizations

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Medications and Dosages (include supplements and OTC Meds)	List Allergies to Medications, Foods, Metals, Latex, Etc

Family Medical History

Breast Cancer	yes	no	Who? ______	Thyroid Disorders	yes	no	Who? ______
Ovarian Cancer	yes	no	Who? ______	Cardiovascular Disease	yes	no	Who? ______
Colon Cancer	yes	no	Who? ______	Diabetes	yes	no	Who? ______
Other Cancers	yes	no	Who? ______	Hypertension	yes	no	Who? ______
Heart Defects	yes	no	Who? ______	Autoimmune Disease	yes	no	Who? ______
Spinal Defects	yes	no	Who? ______	Other	yes	no	Who? ______

Pregnancy History

Date	Outcome (Vaginal, C/S, miscarriage, termination, ectopic pregnancy)	Number of Weeks (if applicable)	Weight (if applicable)	Gender (if applicable)	Details of any treatments, complications, birth defects, still birth, etc

Additional: ______________________

Gynecologic History

Prior Pap Smear	yes	no	When? ______	History of Chlamydia	yes	no	When? ______
Prior Abnormal Pap	yes	no	When? ______	History of Gonorrhea	yes	no	When? ______
Prior Mammogram	yes	no	When? ______	Genital Warts	yes	no	Treatment? ______
Fertility Treatments	yes	no	Kind? ______	History of Herpes	yes	no	
Contraception	yes	no	Kind? ______	Prior HPV Infection	yes	no	Treatment? ______
HPV Vaccinations	yes	no	When? ______	Other	yes	no	What? ______

Social History

Smoking Currently	yes	no	How much? ______	In a Relationship	yes	no	Kind? ______
Former Smoker	yes	no	When quit? ______	Employed	yes	no	Who? ______
Alcohol	yes	no	How much? ______	Occupation	Type? ______		
Recreational Drugs	yes	no	Kind? ______				

Physician/Nurse Use Only Reviewed By: Date:

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