Patient Information Chart # ______________

Name ______________________________________ Date of Birth ______________ Age ________
Address ____
City ________________________________ State ____________ Zip ____________
Social Security # ______________________ Marital Status ______________ Ethnicity ____________
Phone ________________________________ Can we leave a message? ______Yes ______ No
Highest level of education completed ___________________

Emergency Contact

Name________________________________Relationship __________ Phone __________________

Pregnancy History

First day of last menstrual period ____________________________ (month/date/year)

______ Total number of previous pregnancies ______ Total Live Births ______ Total C-sections
______ Total Miscarriages ______ Total Abortions
__________________________________ Ages of living children, if applicable
Did you have any complications during or after your pregnancies? ______ Yes ______ No
If yes, please explain ____
Are you currently breast-feeding? ______ Yes ______ No

Birth Control Information

Were you using a birth control method when you became pregnant? ______ Yes ______ No
If yes, what type? _____________________________________
Have you ever used any of the following birth control methods? Check all that apply

______ Birth control pills ______ Depo-Provera ______IUD ______ Patch
______Nexplanon ______NuvaRing ______Condom ______ Other

Did you have any problems with the method(s) used? ______ Yes ______ No
If yes, please explain ____

Are you interested in being prescribed birth control today? ______ Yes ______ No

I declare that to the best of my knowledge and belief that the above information provided is true and correct.
I have read and agreed to the privacy notice of Bristol Women's Health. A copy will be provided upon my request.

____ ________________
Patient Signature Date

____ ________________
Parent/Legal Guardian/Interpreter Signature Date

Bristol Women's Health
Medical History

Chart # ____________________

Patient Name: ____________________________________ DOB: ______________________

Please list the pertinent information below. If none, write "none"
Allergies ____
____
Medications (prescription and over-the-counter)____________________________________
____
Surgical History ____
____
Medical History ____
____

Do you smoke cigarettes/vape? _______ Yes _______ No If yes, how much? _______/day
Do you drink alcohol? _______ Yes _______ No If yes, how much? _________________

Are you or have you ever been addicted to any substance(s)? _______ Yes _______ No
If yes, what substance(s) and when? ____

Are you currently taking any of the following medications?

- Darunavir (Prescobix, Prezita) _______ Yes _______ No
- Kaletra _______ Yes _______ No
- Reyataz _______ Yes _______ No
- Suboxone (Subutex, Zubsolv, Buprenorphine) _______ Yes _______ No
- Naloxone _______ Yes _______ No
- Posaconazole (Noxafil) _______ Yes _______ No
- Plavix _______ Yes _______ No
- Naltrexone _______ Yes _______ No
- Steroids _______ Yes _______ No

Do you now or have you ever had any of the following? (Please check all that apply)

_______Uterine Fibroid Tumor	_______ Infection of Ovaries/Tubes	_______ Cancer
_______ Hepatitis	_______ Heart Disease	_______ Diabetes
_______ Liver Disease	_______ Thyroid Disease	_______ Sickle Cell Anemia
_______ Blood Clotting Disorder	_______ Anemia	_______LEEP Procedure
_______ Abnormal Pap Smear	_______ Sexually Transmitted Disease	

______________________________________ ______________________
Patient Signature Date

______________________________________ ______________________
Parent/Legal Guardian/Interpreter Signature Date