

**Canton Women's Center
History Update 2017**

Name: _____ **Date:** _____

Please help us update your medical records by answering the following questions. Thanks.

Marital Status: M S D W # **Pregnancies:** ___ # **Miscarriages** ___ # **Living Children:** _____

Current Birth Control: _____

Last Menstrual Period: _____ **Age of Menopause:** _____

Allergies: _____

Medications: _____

New Surgeries: _____

Social History:

Smoking	___ YES	___ NO	Packs per day: ___	# Years: ___	Quit? ___
Alcohol	___ YES	___ NO	Drinks per day: _____		
Drugs	___ YES	___ NO	Which: _____		

Medical History of:

Diabetes	___ YES	___ NO	___ New?
High Blood Pressure	___ YES	___ NO	___ New?
Asthma or Lung Disease	___ YES	___ NO	___ New?
Cancer	___ YES	___ NO	___ New? Where: _____
Depression / Anxiety	___ YES	___ NO	___ New?
Thyroid Disease	___ YES	___ NO	___ New?
Abnormal pap Smear	___ YES	___ NO	When: _____

Other Medical Problems: _____

Patient Signature: _____

Date: _____