



# MT HOOD WOMEN'S HEALTH, P.C.

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Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Circle conditions which have occurred in any of your BLOOD RELATIVES

Diabetes	Heart Disease	Stroke
High Blood Pressure	Bleeding Problems	Depression
Gyn. Cancer	Osteoporosis	Breast cancer

### Circle conditions which YOU have or have had

Diabetes	Heart Disease	Sexually transmitted disease
High Blood Pressure	Bleeding Problems	Depression
Gyn. Cancer	Osteoporosis	Breast cancer Breast lumps
Abnormal Pap smear	Chronic yeast inf.	Loss of Menses
Eating Disorder	Broken bones	Stroke

### ARE YOU ALLERGIC TO ANY MEDICATIONS?

\_\_\_\_\_

### PREGNANCY HISTORY:

Number of Pregnancies \_\_\_\_\_  
 Number of Children \_\_\_\_\_  
 Miscarriages \_\_\_\_\_  
 Abortions \_\_\_\_\_  
 Number of C-sections \_\_\_\_\_  
 Number of Vaginal Deliveries \_\_\_\_\_

### BIRTH CONTROL METHOD:

\_\_\_\_\_  
(if oral contraceptive, please name pill)

Previous Surgeries: \_\_\_\_\_

If Hysterectomy, please list date and reason \_\_\_\_\_

First day of last menstrual period \_\_\_\_\_

Date of last Pap smear \_\_\_\_\_ Results \_\_\_\_\_

Date of last Mammogram \_\_\_\_\_ Results \_\_\_\_\_

List any medications you take regularly \_\_\_\_\_

\_\_\_\_\_

Do you currently use Tobacco \_\_\_\_\_ Amount per day \_\_\_\_\_

Have you ever used Tobacco \_\_\_\_\_ Amount \_\_\_\_\_

Do you currently use Alcohol \_\_\_\_\_ Amount per week \_\_\_\_\_

Have you ever used Alcohol \_\_\_\_\_ Amount \_\_\_\_\_

Do you use Illicit Drugs \_\_\_\_\_ Amount \_\_\_\_\_

Have you ever used Illicit Drugs \_\_\_\_\_ Amount \_\_\_\_\_

Reason for today's visit? \_\_\_\_\_