Canton Women's Center
History Update

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: _____