EMW Women's Surgical Center
Medical History

Date:_____

First Name:_____ Last Name:_____

Birthdate:_____ Age:_____ Phone:_____

Do you have any allergies to medications?_____

Do you drink alcohol?_____ How many drinks a week?_____

Do you do drugs?_____ Which drugs?_____

Do you smoke?_____ How much per week?_____

Do you have any medical illnesses?_____

What medications do you take?_____

What surgeries have you had?_____

When was the first day of your last menstrual period?_____

Have you had any sexually transmitted diseases?_____

When was your last pap smear?_____ -

Have you had any biopsies or procedures done to your cervix? _____

How many vaginal deliveries have you had?_____

What year(s) did you deliver in? _____

How many C-sections have you had?_____

What year(s) did you have C-sections in? _____

Did you have any complications from your deliveries?_____

Have you had any miscarriages? _____

Have you had any abortions? _____

To the best of my knowledge, the information I have provided is accurate and complete:

_____ _____

Signature Date