Women's Health Associates, P.C.

Name_____ Preferred Name_____ Date_____
Date of Birth _____ Age_____ Occupation _____
Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Engaged Partner's name, if applicable _____
What is your pharmacy & phone number for prescription refills? _____
Reason for today's visit: ❑ Routine physical exam ❑ Problem ❑ Consultation- referred by: _____
Please provide details if this is a consultation/problem visit: _____
_____
_____
_____
_____
_____
_____
Do you have any drug, peanut or latex allergies? ❑ Yes ❑ No If yes, please list: _____
_____

Please list your current medications

Prescription Medications	**Reason for taking**	**Prescribed by:**

Please list any Over the Counter medications you take:_____
_____

Do you take any: ❑ Multivitamins ❑ Prenatal vitamins ❑ Omega-3 fish oils ❑ Calcium ❑ Vitamin D ❑ Co-Q10
Others:_____

Past Medical History (please check all that apply)			
Anxiety		High Blood Pressure	
Asthma		High Cholesterol	
Bleeding disorders		Kidney infections	
Blood transfusion		Kidney stones	
Breast Cancer		Migraine headaches	
Cancer (what kind?)		Osteoporosis or bone thinning	
Celiac disease		Rheumatic Fever	
Chronic Lung Disease		Seizure disorder	
Deep vein thrombosis/Pulmonary embolism		Stroke	
Depression		Thyroid disease	
Diabetes		Tuberculosis	
Eating Disorder		GERD	
Gallbladder		Ulcers of the stomach	
Glaucoma		Other:	
Heart Disease			
Hepatitis/Liver disease			

When was your last test or immunization?			
	Date		Date
Mammogram		Tetanus	
Colonoscopy		Flu vaccine	
Bone Density Scan (DXA)		Pneumococcal vaccine (age 65 and older)	
Cholesterol screen		Shingles vaccine (age 60 and older))	
Diabetes screen		Meningitis vaccine	
Vitamin D		Gardasil vaccine	

Please list any past surgeries or hospitalizations

Date	GYN Surgeries	Date	Other Surgeries

Menstrual History

What date was **first day** of your last menstrual period? _____ **or onset of menopause?** _____ age

Age of first period:_____ Are your periods once a month ❑ or irregular ❑

Days of menstrual flow _____ your flow is: ❑ light ❑ moderate ❑ heavy (soaking pad or tampon < 1 hour)

Are your cramps: ❑ mild ❑ moderate ❑ severe? Do you take medicine for menstrual pain/cramps? . . . . . ❑ Yes ❑ No

What medicines do you take?

Do you bleed between periods? . . . . . ❑ Yes ❑ No

Do you bleed after intercourse? . . . . . ❑ Yes ❑ No

Do you have PMS the week before and/or during your period? . . . . . ❑ Yes ❑ No

Have you ever been diagnosed with: ❑ PCOS ❑ endometriosis ❑ fibroids ❑ infertility . . . . . ❑ Yes ❑ No

If you are menopausal, have you had any bleeding or spotting since periods stopped? . . . . . ❑ Yes ❑ No

Date of last pap _____ Do you have a history of an abnormal pap or told the HPV was positive? . . . . . ❑ Yes ❑ No

Have you ever had treatment for an abnormal pap? (Colposcopy, biopsy, Cryo, Laser, LEEP, cone biopsy, conization or hysterectomy?) If yes, year you received treatment: _____ . . . . . ❑ Yes ❑ No

Sexual History

Are you currently sexually active with anyone? . . . . . ❑ Yes ❑ No

Are you sexually active with: ❑ Male ❑ Female ❑ Both Male and Female . . . . . ❑ Yes ❑ No

How many partners have you had in the past year?_____

Have you had more than 5 sexual partners in your lifetime? . . . . . ❑ Yes ❑ No

Do you have pain with sexual activity? . . . . . ❑ Yes ❑ No

Do you have any sexual issues to discuss today? . . . . . ❑ Yes ❑ No

What do you use to prevent pregnancy?

____ nothing
____ birth control pills: Brand Name _____
____ withdrawal
____ Nuva Ring
____ condoms
____ Evra Patch
____ Natural Family Planning
____ Implanon: date inserted _____
____ vasectomy
____ Mirena IUD: date inserted _____
____ tubal ligation
____Paraguard: date inserted _____
____ hysterectomy
____Essure

Are you happy with your current method of birth control? If no, describe problem . . . . . ❑ Yes ❑ No

_____

Do you have any history or sexually transmitted disease? (*please check all that apply)* . . . . . ❑ Yes ❑ No

Chlamydia____ gonorrhea____ herpes____ genital warts____ syphilis____ HIV____

Would you like to be tested for sexually transmitted diseases? . . . . . ❑ Yes ❑ No

Do you have any history of sexual abuse? . . . . . ❑ Yes ❑ No

Has anyone hurt you or hit you in the past year? . . . . . ❑ Yes ❑ No

Do you feel **unsafe** or **threatened** in your home? . . . . . ❑ Yes ❑ No

OB History

	Number		Number

Total number of pregnancies		Full term births	
Abortions		Premature (less than 37 weeks)	
Miscarriages		Living children	
Tubal pregnancies		Twins	

No.	Birth Date	Weeks Gest.	Delivery Type		Early Labor?	Sex	Weight	Complications	Baby's name	Place of Delivery
			C/S	Vag						
1										
2										
3										
4										
5										
6										

Family History

Who in your family have any of the following?

Breast Cancer		High Blood Pressure	
Ovarian Cancer		Stroke	
Colorectal Cancer		Heart Disease < age 55	
Diabetes		Blood Clots (legs/lungs)	
Thyroid disease		TB/Hepatitis	
Osteoporosis		Other	

Social History and Health Maintenance

Do you use Seat Belts? ❑ Yes ❑ No

Do you perform monthly breast exams? ❑ Yes ❑ No

Do you eat dairy products or drink milk? ❑ Yes ❑ No

Do you take a calcium supplement? ❑ Yes ❑ No

Do you take a vitamin D supplement? ❑ Yes ❑ No

Do you walk or Jog? ❑ Not at all ❑ Less than 3 times a week ❑ More than 3 times a week

Do you smoke? ❑ Yes ❑ No

per day:_____ Number of years smoking?_____

Are you interested in quitting? ❑ Yes ❑ No

Alcohol ❑ Yes ❑ No

Drinks per day: _____ Drinks per week: _____

Recreation drug use ❑ Yes ❑ No

What do you use? _____ How often _____ How long have you been using? _____

What do you use to prevent sexually transmitted diseases? ❑ nothing ❑ condoms ❑ abstinence

Years married/ committed relationship _____ Married more than once? _____
How many times? _____ Husband/Partner's age _____ Health _____

Are you a Jehovah's witness? ❑ Yes ❑ No

Great Job….. You are almost finished!

General Physical Condition or Problems

*Do you **currently** have any problems with any of the following? If yes, please check below.*

General	Notes	**Urinary/Vaginal (cont)**	Notes

- ❑ Fatigue
- ❑ Fever
- ❑ Weight loss
- ❑ Weight gain
- ❑ insomnia

Eyes/ENT (2)

- ❑ Seeing double
- ❑ Headache
- ❑ Sinusitis
- ❑ Ear ringing
- ❑ Trouble swallowing
- ❑ Mouth ulcers

Heart

- ❑ Chest pain
- ❑ Palpitations
- ❑ Leg swelling
- ❑ Varicose veins

Lungs

- ❑ Short of breath
- ❑ Wheezing
- ❑ Cough
- ❑ Coughing blood

Breasts/Skin

- ❑ Lumps
- ❑ Pain
- ❑ Nipple discharge
- ❑ Rash
- ❑ Ulcers
- ❑ Suspicious moles
- ❑ Acne

Gastrointestinal

- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea/Vomiting
- ❑ Abdominal pain
- ❑ Bloody stools
- ❑ Fecal loss
- ❑ Hemorrhoids

Urinary/Vaginal

- ❑ Frequent urination
- ❑ Urgency
- ❑ Pain with urination
- ❑ Blood in urine
- ❑ Urine leakage
- ❑ Urination at night >2
- ❑ Incomplete emptying
- ❑ Vaginal odor
- ❑ Painful intercourse
- ❑ Vaginal sores
- ❑ Abnormal bleeding

Musculoskeletal

- ❑ Joint pain or swelling
- ❑ Muscle pain
- ❑ Back pain

Neurological

- ❑ Fainting
- ❑ Seizures
- ❑ Numbness
- ❑ Trouble walking
- ❑ Muscle weakness

Psychiatric

- ❑ Anxiety
- ❑ Depression
- ❑ Impulsive behavior
- ❑ Crying spells
- ❑ Mood swings
- ❑ Excessive anger
- ❑ Memory difficulties

Endocrine

- ❑ Hair loss
- ❑ Excessive thirst
- ❑ Hot flashes
- ❑ Heat or cold intolerance
- ❑ Low sex drive

Blood/Lymph

- ❑ Easy bruising
- ❑ Cuts won’t stop bleeding
- ❑ Enlarged lymph nodes

Allergic/Immunologic

- ❑ Frequent illnesses
- ❑ Seasonal allergies

Other Problems

- ❑
- ❑
- ❑
- ❑