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Name: ___________________________________ Name you prefer to be called? _________________________

Referred by: ______________________________ **Primary Care Doctor**: ________________________________

Please circle the reason for your visit today:

Abnormal Radiologic Finding	Breast Symptoms	Pain: Abdominal/Pelvic
Abnormal Papsmear	Contraception Issues	Prolapse
Annual Well Woman Exam	Menopause/Perimenopause Issue	Urinary/Incontinence or Symptoms
Bleeding Problems	Menstrual Symptoms	Vaginal/Vulvar Symptoms

Other/Please explain: ____

Gynecologic History:

Last menstrual period – date: ______________________

Age of first period: _______ Age of menopause: _______

Period Every _________ days. Lasts _________ days.

Heavy Periods? Cramps? PMS/Moodiness?

Night Sweats? Hot Flashes? Decreased Libido?

Sexually Active? Yes No Not Currently Never

Intercourse a problem? No Yes ____________________

Current Birth control method: _________________________

Hysterectomy? No Complete Partial Year ______ Age_____

Hormone Replacement Therapy? Never Short History Current

Obstetrical History:

Total pregnancies: ___________

Full-term deliveries: ___________

Preterm deliveries: ______ Weeks: ______

Miscarriages: _______ Abortions: ______

Ectopic/Tubal Pregnancies: __________

Twin Pregnancies: _______

Living Children: _________

Largest: _________lb _________ oz

C-Sections: __________

Complications: ___________________ None

Last Pap smear Date: ____________ Abnormal Pap? Date: _______ Tx for Abnormal Pap: ___________________

Do you do regular Breast Self Exams? Yes No Occasionally Last Mammogram date: __________________

DEXA Bone density scan? No Yes Year ____________ Results: Normal Osteoporosis Osteopenia

Screening Colonoscopy? No Yes Year ____________ Results: Normal Polyps Diverticulosis Colon Cancer

Gardasil Vaccine? _____________________ Infection History (STD's) __________________

Past Medical History:

High Blood Pressure	Hypothyroidism/Hyperthyroidism	Breast Cancer
Heart Disease/Stents/Heart Valve	High Cholesterol	Headaches
Heart Attack/MI	Diverticulosis/Diverticulitis	Cataracts or Macular Degeneration
Congestive Heart Failure	Asthma or Chronic Bronchitis	Glaucoma
Diabetes	Kidney Stones	Blood clotting disorder/DVT/PE
Stroke/TIA	Anxiety/Panic attacks	Osteopenia/Osteoporosis
GERD, Reflux	Depression	Other: ________________________

Surgical History: Please list all surgeries and biopsies that you have undergone:

Procedure	Date (year)	Procedure	Date (year)

Have you ever had any problems with anesthesia? o Yes o No Had a Blood transfusion o Yes o No

*****PLEASE COMPLETE BOTH SIDES OF THIS FORM *****

Name: ____

Medications: including vitamins, herbal and over the counter medications: **Allergies** to Medications

Medication and Dose	Medication and Dose	Allergies
1.	6.	
2.	7.	
3.	8.	
4.	9.	
5.	10.	No Know Drug Allergies
Pharmacy Name & Location:	Pharmacy # ( ) -	

Are there any supplies that you get from a Home Health Company? (e.g. Glucose strips, cane walker, toilet….etc)

Family History:

Unknown Family History	What family relation	Age of death
High blood pressure		
Diabetes		
Heart Attack/Heart Problems		
Stroke		
Breast, Ovarian, Uterine, Cervical Cancer (circle)		
Other Cancer – Type ______________________________		
Colon Cancer		
Depression/Anxiety		
Thyroid Disease		
Elevated Cholesterol		
Osteoporosis		
BLOOD CLOTTING DISORDER		
OTHER:		

Social History:

Are you: Single Engaged Married Separated Widowed Divorced Long Term Relationship

What is your diet like? ________________________________Calcium per day? ____________mg None Don't know

What is your occupation? _________________________________Do you exercise? No Daily Regularly Occasionally

Do you smoke cigarettes? Never smoked ______pack/s per day quit smoking _______(Year)

Do you drink alcohol? Never Rare Occasional _______drinks/wk Use any illicit drugs? Yes No

Wear seat belts? Yes No Smoke detector? Yes No Immunizations up to date? Yes No

Have you ever been abused? No Yes Physically Sexually Emotionally Verbally Safe now? Yes No

Review of Systems: Please circle any other symptoms that you may be having:

General: Weight gain, Weight loss, Fatigue, Loss of height

Eyes: Vision changes, Blurring, Corrective lenses

Ears, Nose, Mouth, Throat: Drainage, Discharge Hoarseness, Hearing problems, Vertigo

Cardiovascular: Chest Pain, Leg pain with walking Shortness of breath with exertion, Leg swelling

Respiratory: Wheezing, Cough, Sputum production

Gastrointestinal: Nausea, Vomiting, Blood in stools, Change in stools, Diarrhea, Constipation, Pain with BM

Musculoskeletal: Back pain, Arthritis, Weakness

Skin and/or Breast: Rash, Change in moles, Breast lumps, Breast pain, Nipple Discharge

Neurologic: Numbness, Dizziness, Headaches Difficulty walking, Fainting spells, Tremors

Psych: Anxiety, Depression, Difficulty sleeping

Endocrine: Hot/cold intolerance, Excessive thirst

Hematologic/Lymphatic: Easy bruising, Swollen glands Anemia, Blood clotting disorder, Healing problems

Allergy: Seasonal allergies, Steroid Use, Iodine, Latex

Other symptoms: ______________________________

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