

WOMEN'S MEDICINE

Name: _____ DOB: _____ Date: _____ □

Single Married

Who is your family Doctor? _____ Phys Tele #: _____ □

Widowed Divorced

Reason for your visit today? _____

Allergies: _____

| SINCE YOUR LAST VISIT HAVE YOU? | | | |
|---|------------------------------|--|-------------------------------------|
| Discovered you are allergic to anything new? | <input type="checkbox"/> No | <input type="checkbox"/> Yes What? | Reaction?: |
| Had any changes to your health? | <input type="checkbox"/> No | <input type="checkbox"/> Yes What? | |
| Had anyone in your immediate family diagnosed with a serious illness? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| Had a death in your immediate family? | <input type="checkbox"/> No | <input type="checkbox"/> Yes Explain | |
| Received any immunizations? | <input type="checkbox"/> No | <input type="checkbox"/> Yes Type? | |
| Had any pregnancies, miscarriage, or abortions? | <input type="checkbox"/> No | <input type="checkbox"/> Yes # of Preg | Miscarriage Abortions Live Children |
| Had any changes to your period? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Date of Last Menstrual Period: |
| Had any abnormal bleeding? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| Had any pelvic pain? Painful intercourse? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| Had any signs of menopause? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| Regularly done Self-Breast exams? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Are you sexually active? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| Changed sexual partners? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| Had multiple sexual partners? | <input type="checkbox"/> No | <input type="checkbox"/> Yes Circle | Male / Female / Both Total Number: |
| Been treated for any STD's? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| Do you wish to be tested for HIV/ AIDS? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| Been Hospitalized? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Date: |
| Had a pap smear? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Date: |
| Had a Mammogram? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Date: |
| Had a DEXA scan? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Date: |
| Had a sigmoidoscopy or colonoscopy? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Date: |
| Had a stool check for blood? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Date: |
| Had a cholesterol check? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Date: |
| Had a complete physical? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Date: |
| PERSONAL HABITS Do you? | | | |
| Use tobacco products? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | How much? How often? |
| Drink alcohol? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | How often? What kind? |
| Use illegal drugs? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | How often? What kind? |
| Exercise regularly? | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | |
| Take calcium supplements regularly? | <input type="checkbox"/> Yes | <input type="checkbox"/> | |
| List Medications, Herbals and Vitamins you take: | | | |
| REVIEW OF SYMPTOMS – Please answer “Yes” or “No” to the following questions. | | | |

WOMEN'S MEDICINE

| | | | |
|---|---|--|--|
| Constitutional Fever / Chills Yes No Weight Change Yes No Fatigue Yes No Other | Genitourinary Urine leaking Yes No Painful urination Yes No Urinary frequency Yes No Vaginal discharge Yes No | Respiratory Wheezing Yes No Frequent cough Yes No Shortness of breath Yes No Other: | Neurological Seizures/ Fainting Yes No Dizzy spells Yes No Numbness/tingling Yes No Other: |
| Endocrine Excess thirst/Diabetes Yes No Too hot/ cold Yes No Thyroid problems Yes No Other: | Gastrointestinal Abdominal pain Yes No Nausea/ vomiting Yes No Indigestion/heartburn Yes No Constipation/Diarrhea Yes No | Cardiovascular Chest pains Yes No Palpitations Yes No Edema Yes No Other: | Skin Rash Yes No Dark moles Yes No Persistent itch Yes No Other: |
| Musculoskeletal Joint pain Yes No Neck/ back pain Yes No Muscle weakness Yes No Other: | Breast Pain Yes No Discharge Yes No Masses Yes No Other: | Psychologic Are you satisfied with your life? Yes No Feeling depressed? Yes No Have you considered suicide? Yes No Have you been abused? Yes No | |
| FAMILY HISTORY: Mother <input type="checkbox"/> Living <input type="checkbox"/> Deceased Cause _____ Age: _____ Father: <input type="checkbox"/> Living <input type="checkbox"/> Deceased Cause _____ Age: _____ Siblings: Number Living: _____ Number deceased _____ Cause(s)/ Age(s) _____ Children: Number Living: _____ Number Deceased: _____ Cause(s)/ Age(s) _____ DO YOU HAVE A FAMILY HISTORY OF? (If Yes indicate whom and age at diagnosis) Cancer(s) <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Blood clots/DVT _____ <input type="checkbox"/> Breast _____ <input type="checkbox"/> Hypertension _____ <input type="checkbox"/> Pulmonary Embolism _____ <input type="checkbox"/> Ovarian _____ <input type="checkbox"/> Heart Disease _____ <input type="checkbox"/> Osteoporosis _____ <input type="checkbox"/> Uterine _____ <input type="checkbox"/> Cholesterol _____ <input type="checkbox"/> Thyroid Disorder _____ <input type="checkbox"/> Colon _____ <input type="checkbox"/> Other Illnesses _____ <input type="checkbox"/> Other _____ | | | |