

## WOMEN'S HEALTH

### Personal Information

Date\_\_\_\_\_

Name\_\_\_\_\_

Address\_\_\_\_\_

\_\_\_\_\_

Date of birth\_\_\_\_\_ Age\_\_\_\_\_

Work Phone\_\_\_\_\_

Mobile Phone\_\_\_\_\_

Social Security #\_\_\_\_\_

Status: Married ( ) Single ( ) Widow ( )  
Divorced ( )

Emergency Contact\_\_\_\_\_

Phone/Relationship\_\_\_\_\_

### Indicate Reason for Visit

\_\_\_\_\_

\_\_\_\_\_

### GYNECOLOGICAL HISTORY

Last Normal Menstrual Period\_\_\_\_\_

Age Period Began\_\_\_\_\_

Length of Period\_\_\_\_\_

Length of Cycle\_\_\_\_\_

Present Method of Birth Control\_\_\_\_\_

Have you ever used IUD or BC pills\_\_\_\_\_

Date of last Pap smear\_\_\_\_\_

Result\_\_\_\_\_

Date of last Mammogram\_\_\_\_\_

Result\_\_\_\_\_

### Past Surgical History/Hospitalization

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Pregnancy History

# of Abortions\_\_\_\_\_ Year(s)\_\_\_\_\_

# of Miscarriages\_\_\_\_\_ Year(s)\_\_\_\_\_

# of Children\_\_\_\_\_ Year(s)\_\_\_\_\_

Type of Delivery\_\_\_\_\_

Complications\_\_\_\_\_

### ALLERGIES

Allergies to Medications:\_\_\_\_\_

\_\_\_\_\_

Other Allergies\_\_\_\_\_

\_\_\_\_\_

Current Medications (hormones/vitamins/herbs)\_\_\_\_\_

\_\_\_\_\_

Caffeine (cups of coffee/tea/soda per day)

\_\_\_\_\_

Current & past alcohol intake\_\_\_\_\_

# of Cigarettes per day\_\_\_\_\_

Past Use(yrs)\_\_\_\_\_

Exercise (type)\_\_\_\_\_

Frequency\_\_\_\_\_

Last Dental Visit\_\_\_\_\_

Sun Exposure\_\_\_\_\_ SPF\_\_\_\_\_

Describe your diet\_\_\_\_\_

\_\_\_\_\_

**PLEASE CIRCLE & CHECK THE**

**FOLLOWING :**

<b>Do you have a history of:</b>	<b>YES</b>	<b>NO</b>	<b>DATE</b>
Hot Flashes/Vaginal Dryness	_____	_____	_____
Sleep Interruptions	_____	_____	_____
Abnormal/Irregular Periods	_____	_____	_____
Abnormal Pap Smears	_____	_____	_____
Colposcopy/Cryosurgery/Laser Surgery	_____	_____	_____
Genital Warts/Herpes/Chlamydia/Gonorrhea	_____	_____	_____
Pelvic Inflammatory Disease	_____	_____	_____
Infertility/Amenorrhea	_____	_____	_____
Endometriosis/DES Exposure/Fibroids	_____	_____	_____
Ovarian Cancer/Ovarian Cyst	_____	_____	_____
Uterine Cancer	_____	_____	_____
Heart Disease/Murmur	_____	_____	_____
High Blood Pressure/Stroke	_____	_____	_____
Migraines/Epilepsy/Seizures	_____	_____	_____
Varicose Veins/Anemia/Blood Disorders	_____	_____	_____
Depression/Psychological Disorders	_____	_____	_____
Lung Disease	_____	_____	_____
Kidney Disease	_____	_____	_____
Phlebitis/Pulmonary Embolism	_____	_____	_____
Thyroid Disease/Diabetes	_____	_____	_____
Hepatitis	_____	_____	_____
Liver Disease/Gall Bladder Disease	_____	_____	_____
Easy Bruising/Bleeding Problems	_____	_____	_____
Collagen Vascular Disease (Lupus)	_____	_____	_____
Arthritis/Back Problems/Bone Fractures	_____	_____	_____
Urinary/Bowel Problems	_____	_____	_____
Have you ever taken Heparin, Steroids or Thyroid Medication? _____			
Sexual problems _____			
Last cholesterol test date _____ Result _____			
Last fasting sugar blood test _____			

**Patient Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Age:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Insurance:** \_\_\_\_\_

**Home Number:** \_\_\_\_\_

**Work Number:** \_\_\_\_\_

**Referred By:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Operation:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Date:** \_\_\_\_\_

**History:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_