WOMEN'S HEALTH

Personal Information	Pregnancy History		
Date	# of Abortions Year(s)		
Name	# of Miscarriages Year(s)		
Address	# of Children Year(s)		
	Type of Delivery		
Date of birthAge	Complications		
Work Phone			
Mobile Phone	ALLERGIES		
Social Security #	Allergies to		
Status: Married () Single () Widow () Divorced ()	Medications:		
Emergency Contact	Other Allergies		
Phone/Relationship			
Indicate Reason for Visit	Current Medications (hormones/vitamins/herbs)		
	Caffeine (cups of coffee/tea/soda per day)		
GYNECOLOGICAL HISTORY	Current & past alcohol intake		
Last Normal Menstrual Period	# of Cigarettes per day		
Age Period Began	Past Use(yrs)		
Length of Period	Excercise (type)		
Length of Cycle	Frequency		
Present Method of Birth Control	Last Dental Visit		
Have you ever used IUD or BC pills	Sun ExposureSPF		
Date of last Pap smear	Describe your		
Result	diet		
Date of last Mammogram			
Result			
Past Surgical History/Hospitalization			

PLEASE CIRCLE & CHECK THE

FOLLOWING:

I OLLOWING .			
Do you have a history of:	YES	NO	DATE
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 dateResult			
Last fasting sugar blood test			

Patient Name:	
DOB:	
Age:	-
Address:	-
Insurance:	_
Home Number:	-
Work Number:	
Referred By:	-
Date:	
Diagnosis:	_
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	- -
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Operation:	<u>-</u> -
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Date:	
History:	_
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