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)_____

Excercise (type)_____

Frequency_____

Last Dental Visit_____

Sun Exposure_____SPF_____

Describe your diet_____

_____

PLEASE CIRCLE & CHECK THE

FOLLOWING :

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 date_____Result____

Last fasting sugar blood test_____

Patient Name:_____

DOB:_____

Age:_____

Address:_____

Insurance:_____

Home Number:_____

Work Number:_____

Referred By:_____

Date:_____

Diagnosis:_____
_____
_____
_____
_____
_____

Operation:_____
_____
_____
_____
_____
_____

Date:_____

History:_____
_____
_____
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_____
_____
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