Women for Women

Name: _____DOB:_____

The following information assists us in providing you the most excellent care. Please fill out BOTH sides of this form completely

Have you ever had any of the following? (Circle all that apply)

Abnormal pap smear	Depression	Heart disease	Mitral valve prolapse
Anemia	Diabetes	Hemorrhoids	MRSA
Anxiety	DVT	Hepatitis	Osteoporosis
Arthritis	Emphysema	HIV/AIDs	Problem with anesthesia
Asthma	Epilepsy	High cholesterol	Rheumatic fever
Bipolar disorder	Frequent bladder infections	High blood pressure	Stroke
Blood transfusion	Gastric ulcer	Irritable bowel	Lupus
Chlamydia	Genetic carrier	Kidney stone	Thyroid disease: Hypo or hyper
Clotting disorder: _____	Genital herpes	Kidney disease	Cancer, type: _____
Condyloma (genital warts)	GERD	Liver disease	Other: _____
Congenital birth defect	Gonorrhea	Migraines	None

Your most recent:	Date:	Result:	Your most recent:	Date:	Result:
Mammogram			Cholesterol check		
Pap Smear			Bone Density scan		
Colonoscopy					

List All Surgeries and Procedures			
Type	**Year performed**	**Type**	**Year performed**

List all prescription and over-the-counter medications and supplements you take regularly			
Medication	**Dose**	**Frequency (Daily, twice a day…)**	**Prescribing physician**

Medication Allergies			
Medication allergic to:	**Reaction:**	**Medication allergic to:**	**Reaction:**

Gynecologic History	
Menses	**Sexual Information**
Age of first menstruation: _____	Sexually active: Yes No
Menopause NO Yes, since age: _____	Sexual preference: Men Women Both
How many days are your period? _____	Method of birth control: (circle)
How many days apart are your periods? (ie 28days) _____	Virgin Pill Foam/Gel Vasectomy Natural family planning
Last menstrual period: _____	Abstinent IUD Withdrawal Diaphragm Tubal ligation
Do you bleed between periods: NO YES	None Condoms Depo-provera Nuvaring Hysterectomy
Have you received the HPV vaccine? YES NO What age? _____ How many doses? _____	

Family History **If you are adopted and blood relative history is unknown, proceed to next page*

Mother=M Father=P Siblings=S Maternal grandmother=MGA Paternal grandmother=PGA
Maternal grandfather=MGP Paternal grandfather=PGP Maternal Aunt/Uncle: MA/MU Paternal Aunt/Uncle: PA/PU

Problem	Relationship	Age of onset	Problem	Relationship	Age of onset
Anemia			Heart disease		
Asthma			High cholesterol		
Blood disorder			Hypertension		
Blood clots			Kidney disease		
Cancer, type:			Migraines		
Depression			Stroke		
Diabetes: Type I or II			Thyroid Disease		
Epilepsy			Other: _____		

Obstetric History

Date of delivery, miscarriage, or abortion	Weight	Gender (M or F)	Vaginal or C-section	Location/Doctor	Complications

Social History (circle the appropriate answer)

Marital Status: Single Engaged Married Divorced Widowed

Do you smoke? Never former-Quit when? Yes- socially or how many packs per day? ___

Do you drink alcohol? Never Rarely Socially Weekends Daily

Do you drink caffeine? No Yes: 1-2/day 3-4/day

Do you use marijuana? Never Rarely Socially Weekends Daily

Do you use illegal drugs? Never Yes-How much, what kind, and how often?

How much exercise do you get? Sedentary Once a week or less 1-3times a week 4 or more times a week

Do you perform monthly breast self-exams? Never Sometimes Monthly

Please circle any symptoms you are currently having:

Weight gain	Lower leg swelling	Blood in urine	Vaginal odor	Depression
Weight loss	Varicose veins	Urinary frequency	New skin lesions	Difficulty sleeping
Chronic fatigue	Diarrhea	Urinary urgency	Changes in moles	Swollen lymph nodes
Persistent fever	Constipation	Leaking urine	Hot flashes	Season allergies
Frequent headaches	Pelvic pain	Genital sores	Night sweats	
Breast lumps	Blood in stools	Vaginal discharge	Hair loss	
Nipple discharge	Fecal incontinence	Painful periods	Facial hair growth	
Lower leg swelling	Night time urination	Irregular periods	Anxiety	