Specialists in Women's Healthcare, P.C.

Name______________________________ Date______________ D.O.B.___________________
Occupation_________________________________ Marital Status S M D W Age________
What is the purpose of your visit? ____
____
Referred to our office by: ____
If you have a specific problem, please describe briefly: _______________________________
____
How long have you had this problem? ____
Have you consulted anyone else? Y N Who? ___________________________________
Describe any previous testing &/or treatment: ____________________________________
____
____
Please list all medications you are currently taking. Please include over the counter medications and herbal supplements.____
____
____
Do you take calcium? Y N
Please list all allergies to medications, latex, foods: ____________________________________
____

GYNECOLOGY REVIEW

Last Pap smear ____________ Last Mammogram_________________ Last Bone Density____________
Date last period began: ________________________ Age your period began: ____________________

How often does your period come?
- ☐ Less than 20 days apart
- ☐ 21 – 30 days apart
- ☐ 30 – 40 days apart
- ☐ greater than 40 days apart

How many days do you usually flow?
- ☐ Less than 2 days
- ☐ 2 – 7 days
- ☐ 7 – 10 days
- ☐ more than 10 days

I use _____ pads ____ tampons on my heaviest days

Do you stay in bed during your period?	Y	N	Uterine Fibroids	Y	N
Do you bleed or spot in between periods?	Y	N	Ovarian Cysts	Y	N
Do you bleed or spot after intercourse?	Y	N	Uterine Cancer	Y	N
Do you require additional overnight protection?	Y	N	Cervical Cancer	Y	N
Do you have significant pain with your period?	Y	N	Other Cancer__________________		

If yes, what do you usually take? ___________________________ Dosage? __________________
____

Have you reached Menopause?	Y	N	Age of onset__________________		
Do you have hot flashes?	Y	N	Night sweats?	Y	N
Vaginal dryness / painful intercourse?	Y	N	Trouble Sleeping	Y	N
Do you take hormone replacement therapy?	Y	N			

Medication taken: ____
Duration of treatment: ____
Reason for discontinuation? ____
Herbal or natural supplements: ____
What form of birth control do you usually use?

- ☐ Birth control pills /Name_____________________________ for how many yrs. / mos.______________
- ☐ IUD Type / date of insertion__________________________
- ☐ Vasectomy
- ☐ Diaphragm
- ☐ Rhythm / Natural Family Planning
- ☐ Condoms / Foam / Suppositories
- ☐ Tubal Ligation
- ☐ Menopause
- ☐ Hysterectomy
- ☐ Not sexually active
- ☐ Other: _________________________

Do you have pain during or after intercourse? Y N
Do you have any concerns with sexual function / desire? Y N

Do you have concerns with PMS? Y N

Do you perform monthly breast self-exam? Y N
Any significant breast changes that you have noticed? Y N
Do you have: ☐ breast lumps ☐ nipple discharge ☐ breast tenderness
Fibrocystic breast changes____
Do you have a chronic vaginal discharge? Y N
Have you used medication for the discharge? Y N Meds. Used: ______________________
Do you douche? Y N If so, how often? ______________________ What do you use? ______________
Have you been treated in the past for a vaginal infection? Y N

☐ Yeast ☐ Chlamydia ☐ Herpes/HSV virus
☐ Trichomoniasis ☐ Gardnerella ☐ HIV / AIDS
☐ Gonorrhea ☐ Syphilis ☐ Pelvic Inflammatory Disease
☐ Bacterial / BV ☐ HPV / genital warts

Have you ever had an abnormal pap smear? Y N What year? ____________________________________
Describe any treatmen/follow-up:____

Burning on urination Y N
Urinary tract infection Y N
Urinary frequency Y N
Blood in the urine? Y N
How many infections? ____________________________
Urinary urgency Y N
Do you get up in the middle of the night to urinate? Y N
Do you wet yourself when you cough/laugh/exercise? Y N
Have you seen a Urologist in the past? Y N
Do you wear pads for urinary leakage? Y N

SOCIAL HISTORY

Do you consume caffeine daily? Y N
Chocolate______________servings/day
Coffee / Tea __________________ servings/day
Carbonated soft drinks__________ servings/day
Do you consume alcohol on a regular basis? Y N Drinks/week______________________
Do you smoke? Y N How much? ________________________
Have you ever smoke cigarettes in the past? Y N When quit? ________________________
Have you used illicit or IV drugs in the past? Y N ☐ Marijuana ☐ Cocaine ☐ Methadone ☐ Other
Do you exercise? Y N
Do you have any history of family violence? Y N
Do you use a seat belt? Y N
Do you use sun screen? Y N

FAMILY HISTORY

Relationship	Age	State of Current Health	Age at Death	Medical Conditions
Mother				
Father				
Brother				
Sister				
Spouse				

Name____Date of Birth____________________

SURGERIES AND HOSPITALITZATIONS

List all except obstetrical: (Use a separate sheet of paper if more space is needed)

Surgery/Hospitalization	Date	Reason/Diagnosis

OBSTETRICAL HISTORY

Please list pregnancies, miscarriages and terminations from past to current

Date	Vaginal	C-Section	Abortion	Miscarriage	Male/Female	Weight	Complications

IF HERE FOR PREGNANCY CARE, PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Will you be age 35 or older when the baby is due? Y N
2. Have you or the baby's father, or anyone in either of your families ever had:
   A. Down syndrome or mongolism? Y N
   B. Spina bifida or Meningomyelocele (open spine)? Y N
   C. Hemophilia? Y N
   D. Muscular dystrophy? Y N
   E. Cystic fibrosis? Y N
3. Have you or the baby's father had a child born dead or alive at birth with a birth defect not listed in Question 2 above? Y N
4. Do you or the baby's father have any close relatives who are mentally retarded? Y N
5. Do you or the baby's father or close relatives in either of your families have any inherited genetic or chromosomal disease or disorder not listed above? Y N
6. Have you had three or more spontaneous pregnancy losses? Y N
7. Do you or the baby's father have any close relatives descended from Jewish people who lived in Eastern Europe (Ashkenazic Jews)? Y N
8. If patient or the baby's father are Black:
   Have you or the baby's father or any close relatives been screened for sickle cell trait and found to be positive?

Do you have now, or have you had within the past year:
(please circle the correct response beside each question)

Constitutional:

Weakness	Y	N
Tire easily	Y	N
Weight Change	Y	N
Appetite Change	Y	N

Other: ______________________________

Eyes:

Double Vision	Y	N
Blurred Vision	Y	N
Glasses/Contacts	Y	N

Last Eye Exam________________

Other: _______________________________

Ears, Nose, Throat:

Ringing in ears	Y	N
Ear Pain	Y	N
Hearing loss	Y	N
Frequent nose bleeds	Y	N
Sinus problems/Allergies	Y	N
Loss of smell	Y	N
Sore throat	Y	N

Other: ______________________________

Cardiac/Vascular:

Palpitations	Y	N
Heart flutter	Y	N
Chest pain	Y	N
Mitral Valve Prolapse	Y	N

Other: ______________________________

Respiratory:

Chronic cough	Y	N
Shortness Breath	Y	N
Wheezing	Y	N

Other: ______________________________

Endocrinology:

Increased thirst	Y	N
Diabetes	Y	N

Gastrointestinal:

Difficulty Swallowing	Y	N
Heartburn	Y	N
Frequent Belching	Y	N
Nausea / Vomiting	Y	N
Chronic Diarrhea	Y	N
Chronic Constipation	Y	N
Rectal Bleeding	Y	N
Hemorrhoids	Y	N
Irritable Bowel Syndrome	Y	N
Hepatitis A/B/C	Y	N

Other: ______________________________

Musculoskeletal:

Backaches	Y	N
Joint pain/stiff	Y	N
Swollen joints	Y	N
Muscle cramps	Y	N
Swelling of hands/feet/ankles	Y	N

Other: ______________________________

Integumentary (skin):

Skin rash	Y	N

Other: ______________________________

Neurological:

Headaches	Y	N
Seizures	Y	N
Poor Coordination	Y	N
Dizziness/Fainting	Y	N

Other: ______________________________

Psychological:

Depression	Y	N
Memory loss	Y	N

Other: _____________________________

Form Completed by: ☐ Patient ☐ Medical Assistant ☐ Physician ☐ Other	
Signature of Patient:	
Date reviewed by Physician with Patient: / /	Physician Signature:

ANNUAL REVIEW OF HISTORY

Date Reviewed: / /	Physician Signature:
Date Reviewed: / /	Physician Signature:
Date Reviewed: / /	Physician Signature:
Date Reviewed: / /	Physician Signature:

*******For Physician Use Only *******

Date Reviewed	Physician's Initials	Date Reviewed	Physician's Initials	Date Reviewed	Physician's Initials	Date Reviewed	Physician's Initials