Women's Health
Primary Care
Shoreline

**Date of Appointment:** ___________________ **New Patient to WHPC:** Yes/No

**Name:**_________________________________________________________ **Birthday:**__________________ **Age:**____

**Marital Status**: Single/Married/Divorced/Widowed/Partnered (please circle all that apply)

**Occupation**:______________________

**Household Members** (names and ages):_____________________________________________________________________

_________________________________________________________________________________________________________

## Lifestyle Review

**Are you following a special diet?** If so, what kind?___________________________________________________________

**Do you feel your diet is healthy?** Yes/No **Are you happy with your present weight?** Yes/No

**Do you exercise?** Yes/No **If so, how often?** ________________________________________________

**What type of exercise do you do?** ________________________________________________________________________

**When was your last Eye Exam?** ______________________ **When was your last Dental Exam?** ____________________

**Are you or any family or friends concerned about your hearing?** Yes/No

**When was your last hearing evaluation?** ______________________________ **Do you wear hearing aides?** Yes/No

_________________________________________________________________________________________________________

## Social History Review

**Are you exposed to heavy 2nd hand smoke, or does anyone in your household smoke?** Yes/No

**Are you a FORMER smoker?** Yes/No **How many years did you smoke?** _____ **When did you quit?** ____ (Congrats!!)

**Do you CURRENTLY smoke, vape, or use smokeless tobacco?** Yes/No

**How much per day?** ________________ **For how many years?** _____________________

**If yes, would you like help with quitting?** Yes/No **Have you attempted quitting in the past?** Yes/No

**Do you drink alcohol?** Yes/No **If so, do you mainly drink beer, wine or liquor?** ___________

**How many drinks per day?** _____________ **per week?** ______________ **per month?** ______________

**Have you or any family or friends ever expressed concern over your drinking?** Yes/No

**Do you sometimes use street drugs?** Yes/No **If so, what type?**________________________________

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**Family History Review** (please circle all that apply)

| | |
|---|---|
| Stroke, Dementia, Asthma, COPD<br>Sudden, Unexplained Death before age 60 | Diabetes, Thyroid Problem, Lupus, Psoriasis, Rheumatoid arthritis, Metabolic Disorder, PCOS |
| Heart Attack, Heart Disease, High Blood Pressure, High Cholesterol | Cancer of the Breast, Cervix, Ovary, Uterus, or Endometrium |
| Anxiety, Depression, Bipolar, ADHD, Schizophrenia, Suicide, Substance addiction, Substance abuse | Cancer of any other type, please specify: |

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## Menstrual/OBGYN History

**When was your last period?** ____________________

**How frequent are your periods?** _________________

**Do you have any period problems?** Heavy Bleeding/Painful Cramping/Diarrhea/Mood Swings

**Do you use birth control?** Yes/No **If so, what kind?** ___________________________

**Are you sexually active?** Yes/No **Are you happy with your current birth control?** Yes/No

**How many partners in the past 5 years?** ______ Men/Women/Both

**Have you ever been pregnant?** Yes/No **How many pregnancies?** _____ **How many births?** ______

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**When was your last:**

Pap smear? _______________________ Mammogram?______________________

Bone Density test?_________________ Colonoscopy? ______________________

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## General Risk Screening

**Do you wear.....** **Seatbelts?** Yes/No **Sunscreen?** Yes/No **Helmets?** Yes/No

**Do you have working smoke detectors and carbon monoxide detectors at home?** Yes/No

**Do you have unsecured firearms in your home?** Yes/No

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## Medical History

**Do you have any Allergies to Medications, Foods, Insects or Environmental triggers?** Yes/No

**Please list:**___________________________________________________________________________

**Do you take any Medications or Supplements?** Yes/No

Please list below. Include all pills, liquids, suppositories, eye drops, creams, nose sprays, vitamins, inhalers, hormones, birth control, prescriptions and over the counter medications.

| Medication Name | Dose | Frequency | Medication Name | Dose | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Please list all conditions for which you are currently being treated for by any health care provider:**

_____________________________________________________________________________________________

_____________________________________________________________________________________________

**Please list any surgeries you have had:**

_____________________________________________________________________________________________

_____________________________________________________________________________________________

***Do you have any concerns you'd like to discuss today?*** Yes/No ________________________________________

**Recent Symptoms** (circle all that apply)

| | |
|---|---|
| **General:** Weight gain/loss, Fever, Chills, Fatigue | **Eyes:** Vision changes, irritation, |
| **ENT:** hearing loss, ear pain, snoring, sore throat, runny nose, sinus problems | **Cardiovascular:** Chest pain, Palpitations, Leg swelling, Blood clots, Prolonged bleeding |
| **Respiratory:** Cough, Sputum production, shortness of breath, wheezing | **GI:** Abdominal pain, Nausea, Vomiting, Diarrhea, Constipation, Blood in stool |
| **GU:** Pain with urination, urinary frequency, urgency, blood in the urine, kidney stones | **Endocrine:** Excessive thirst, Excessive urination, intolerant to heat or cold |
| **Skin:** Rash, Blisters, new or changing lesions | **Neuro:** Headache, Numbness or tingling |
| **Mood:** Anxious, Depressed, Sad, Agitated | **Musculoskeletal:** Muscle aches, Joint pain/swelling, Back pain, Neck pain, Restricted joint mobility |

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# Mental Health Screening

## PHQ-9

| Over the last 2 weeks, how often have you been bothered by any of the following problems? | Not at all | Several Days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | | | | |
| 2. Feeling down, depressed, or hopeless | | | | |
| 3. Trouble falling or staying asleep, or sleeping too much | | | | |
| 4. Feeling tired or having little energy | | | | |
| 5. Poor appetite or overeating | | | | |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | | | | |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | | | | |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | | | | |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | | | | |

*If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?*

| **Not difficult at all** | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|

## GAD-7

| Over the last 2 weeks, how often have you been bothered by any of the following problems? | Not at all | Several Days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on edge | | | | |
| 2. Not being able to stop or control worrying | | | | |
| 3. Worrying too much about different things | | | | |
| 4. Trouble relaxing | | | | |
| 5. Being so restless that it is hard to sit still | | | | |
| 6. Becoming easily annoyed or irritable | | | | |
| 7. Feeling afraid as if something awful might happen | | | | |