Name: _____ **Date of Birth**: _____ **Date:** _____

Referring Doctor: _____ **Primary Care Doctor:** _____

Preferred Language:_____

Ethnicity: ____ Hispanic or Latino ____ Not Hispanic or Latino ____ Unknown ____ Declined to specify

Race: ____ American Indian ____ Alaska Native _____ Asian _____ Black or African _____ Native Hawaiian _____Other Pacific Islander

_____ White _____ Unknown _____ Declined to specify

How would you like to receive reminders from our office? ___Phone___Email___Secure Message on the Portal___Decline to Specify___Do not Wish to Receive Reminders

Why are you seeing the doctor today? _____

How long have you had this problem? _____

What improves or worsens the problem/pain? _____

Are there any symptoms that go along with the problem/pain? _____

Is the problem/pain continuous or does it come and go? _____

Describe the pain (sharp/dull, etc.) _____

Have you tried any medicine/treatment for this problem/pain? _____

What is your goal for today's visit? (2nd opinion, reassurance, improve symptoms, cure)_____

CURRENT MEDICATIONS – Please list ALL medications you are currently taking including over the counter meds

Drug Name:	**Strength:**	**Directions/How you take it:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Attach list if necessary

I give Women's Health Specialty Care permission to download my medication history: _____
Patient Signature

Pharmacy Name: _____ **Phone #:** _____

Pharmacy Address: _____

ALLERGIES – Please list ALL types (Drug, seasonal, pets, environmental foods)

_____

_____

By what method did you choose our practice:

_____Referring Physician _____Friend _____Yellow Pages _____Insurance Company _____Other

SOCIAL HISTORY

Please provide the following information:

Marital Status: Please indicate years

_____Single _____Married _____Separated ____Divorced ____Widowed ____Life Partner ____Common Law Spouse

Pregnancy

# of Pregnancies _____ # of Live Births _____ # Vaginally Delivered _____ # of C-Sections _____ Vaginal Tears at Delivery Y / N

Occupation: _____

Alcohol Consumption:

_____None _____Yes _____ Occasional/Social # of drinks per day _____ History of Abuse: _____None _____Yes

Tobacco Use:

Cigarettes_____ Smokeless_____ Other:_____

Tobacco per day:

_____None _____Yes #_____ Packs/day _____ How many years?

If you previously smoked and stopped, when? _____ How long? _____

Recreational Drugs:

_____None If yes, please list: _____ History of Abuse: _____None _____Yes

Caffeinated beverages:

_____None _____Low _____Moderate _____Excessive # of cups of coffee per day: _____

REVIEW OF SYSTEMS: Are you feeling any of these symptoms today?

Constitutional
Anorexia
Aches and Pains
Chills
Easy Bruising
Fever
Fatigue
Generalized Weakness
Insomnia
Night Sweats
Sleep Apnea
Weight Gain
Weight Loss

Eyes
Blind
Blurred Vision
Double Vision
Glaucoma
Worsening Eyesight

Allergic/Immunologic
Drug Allergies
Environmental Allergies
Food Allergies
Seasonal Allergies

Neurological
Balance Problems
Disoriented
Dizzy Spells
Headache
Lack of Alertness
Leg or Arm Weakness
Memory Loss
Numbness/Tingling
Stroke
Speech Problems
Tremors

Endocrine
Diabetes
Excessive thirst
Tired/Sluggish
Too Hot/Cold

Gastointestinal
Abdominal Cramps
Abdominal Pain
Acid Reflux
Bloody Stools
Change in Bowel Habits
Constipation
Diarrhea
Flatulence
Gas
Hemorrhoids
Indigestion/heartburn
Irregular Bowel Movements
Nausea/vomiting
Rectal Bleeding
Tarry Stool

Cardiovascular
Chest Pain/Angina
Palpitation
Shortness of Breath
Swelling

Skin
Acne
Boils
Changing Moles
Persistent Itch
Pigment Change
Skin rash

Musculoskeletal
Back Pain
Joint Pain
Muscle Cramps
Muscle Weakness

Ear/Nose/Throat
Sinus Problem

Genitourinary
Back Pain
Bedwetting
Blood in Urine
Dribbling
Burning on Urination
Hesitancy
Infertility
Leak after voiding
Leak when cough/sneeze
Low Libido
Lower abdominal pain
Not Emptying
Painful Intercourse
Rush to get to bathroom
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Tract Infections
Urine retention
Vaginal Bleeding
Vaginal Discharge/Problems
Waking at night to void
Weak Stream

Respiratory
Frequent Cough
Shortness of breath
Wheezing

Hematological/Lymphatic
Swollen Glands
Blood clotting problem
Bleeding Problem

Psychologic
Anxiety
Depressed
Generally satisfied with life

PAST MEDICAL HISTORY

Please CIRCLE if you have or have had any of the following diseases or conditions:

Cardiovascular
Anemia
Angina
Aortic Aneurysm
Aortic Regurgitation
Aortic Stenosis
Arrhytmia
Atrial Fibrillation
Bleeding Disorder
Cardiomyopathy
Cerebrovascular Disease
Claudication
Congenital Heart Disease
Congestive Heart Failure
Coronary Artery Disease
Deep Vein Thrombosis
Endocarditis
Enlarged Heart
Heart Attack
Heart Block
Heart Disease
Heart Murmur
Heart Valve Problem
Hemophilia
Hypertension
Leukemia
Mitral Insufficiency
Mitral Stenosis
Mitral Valve Prolapse
Rheumatic Fever
Sickle Cell Anemia
Stroke
Thrombophlebitis
Varicose Veins

Endocrine/Metabolic
Diabetes Mellitus
Goiter
Gout
Hyperthyrodism
Hypothyrodism
Impaired Glucose Tolerance

General
Allergies
Electrical Injury
Exposure to Chemicals
Hepatitis A
Hepatitis B
Hepatitis C
Hypercholestolemia
Hyperlipidemia
Infectious Disease
Lipid Disorder
Paget's Disease
PCKD
PCO
Raynaud's Syndrome
Sleep Apnea

GI
Accidental bowel leakage
Chronic Liver Disease
Colitis
Constipation
Colon Condition
Crohn's Disease
Diarrhea
Diverticulitis
Diverticulosis
Gall Bladder Disease
GERD
Hemorrhoids
Hepatic Failure
Hepatitis
Hiatal Hernia
Inflammatory Bowel Disease
Liver Disease
Pancreatitis
Peptic Ulcer (Duodenal)
Rectal Fissure
Stomach Ulcer
Ulcerative Colitis

GU
AIDS/HIV
Bladder Cancer
Bladder Outlet Obstruction
Bladder Stone
Bladder Infection/UTIs
Renal Insufficiency
Renal Failure
Interstitial Cystitis
Kidney Cancer
Kidney Disease
Kidney Infection
Kidney Stones
Neurogenic Bladder
Polycystic Kidney Disease
Prostate Cancer
Radiation or Nuclear
Exposure/Therapy for cancer
Testicular Cancer
Transplant Recipient
Ureteral Cancer
Venereal Disease

GYN/OB
Breast Cancer
Breast Disease
Endometriosis
Menopause *
Menstrual Problems
Osteoporosis
Ovarian Cancer
Polycystic Ovaries
Uterine Fibroids

HEENT
Blindness
Cataracts
Deviated Septum
Deafness
Ear Infections
Glaucoma
Hay Fever
Menniere's
Mumps
Sinusitis
Tinnitis
Vertigo

Musculoskeletal
Arthritis
Carpal Tunnel Syndrome
Fibromyalgia
Mortons Neuroma

Neurological/Psychological
ADD
ADHD
Alcoholism
Alzheimer's Disease
Anxiety
Bi-polar Disorder
Chronic Fatigue Syndrome
Dementia
Depression
Eating Disorder
Epilepsy
Herniated Disc
Mental Illness
Migraine
Multiple Sclerosis
Nervous Breakdown
Organic Brain Syndrome
Parkinson's
Polio
Seizures
Spinal Cord Injury
Stroke
Suicide Attempt

Respiratory
Asthma
Bronchitis
Chronic Lung Disease
COPD
Emphysema
Lung Disease
Pneumonia
Pulmonary Embolism
Tuberculosis

Tumors
Brain Tumor
Breast Cancer
Cervical Cancer
Colon Cancer
Fibrocystic Breast Disease
Gastric Cancer
Kidney Cancer
Laryngeal Cancer
Lung Cancer
Lymphoma
Melanoma
Ovarian Cancer
Pancreatic Cancer
Rectal Cancer
Sarcoidosis
Testicular Cancer
Bladder Cancer
Ureteral Cancer
Uterine CA

When was your last menstrual period? _____ How is your cycle? Regular_____ Irregular_____
Date of last mammogram:_____
Date of last pap smear:_____
*Age of menopause: _____
Have you experienced any vaginal bleeding since menopause? Y / N
Have you used hormone replacement therapy? If so, what type?_____
Are you currently sexually active? Y / N
Do you experience pain with intercourse? If so, what type? _____Superficial Penetration _____ Deep Penetration _____Both
Has anyone ever forced you to participate in sexual acts when you did not want to? Y / N
Have you had a colonoscopy within the last 9 years or a fecal occult blood test within the last year? If so, when?_____
Have you had a influenza (flu) shot this season? If so, when? _____
Have you had a pneumonia vaccination? If so, when? _____
Other:_____
_____

SURGICAL HISTORY

Please CIRCLE if you have had any of the following surgeries and date of surgery:

Cadiovascular
Angioplasty
Aortic Aneurysm Repair
CABG
Carotid Artery Surgery
Heart Surgery
Heart Surgery/ (Stents)
Heart Transplant
Pacemaker Insertion
Vein Stripping

General
Abdominoplasty
Brain Surgery
Breast Implants
Laminectomy
Lymphatic Node Dissection
Parathyroidectomy
Pilondial Cyst Incision
Skin Grafting
Tummy Tuck

GI
Appendectomy
Bariatric Surgery
Bowel Resection
Cholecystectomy/Gall Bladder Removed
Colon Resection
EGD
EGD/Dilation Esophagus
Fissurectomy
Gastric Surgery
Hemorrhoidectomy
Ileostomy
Laparoscopy
Liver Surgery
Liver Transplant
Lumpectomy of Breast
Lysis Adhesions
Nissen Fundoplication
Splenectomy
Stomach Surgery
Umbilical Hernia
Ventral Hernia Repair

GU
Bladder Surgery
Biopsy Prostate
Contigen/Coaptite
Cystoscopy
Cystoscopy-Dilation
Cystoscopy-Retrograde
Cystoscopy-Stent
Cysto-TUR Fulguration
Durasphere
ESWL
Herniorrhaphy
Ileal conduit
Inguinal Herniorraphy
Interstim
Kidney Removal
Kidney Stone
Laser Lithotripsy
Nephrolithotomy
Orchiectomy
Orchiopexy
Penile Implant
Penectomy
Renal Transplant
TOT/TVT/Sling
TURBT
Ureteroscopy
Variocelectomy
Vasectomy

GYN
Ablation
Bladder Lift
Breast Reduction
Breast Surgery/Benign
Cystocele Repair
C- Section
D and C
Endometrial Ablation
Hysterectomy, Abdominal
Partial or Complete
Hysterectomy, Vaginal
Partial or Complete
Mastectomy
Ovary Removal or Cysts
Rectocele Repair
Tubal Ligation Bilateral

HEENT
Cataract Surgery
Corneal Surgery
Ear Surgery
Eye Surgery
Facial Surgery
PE Tubes
Septoplasty
Sinus Surgery
Tonsil Surgery
Thyroid Surgery
TMJ Surgery

Musculoskeletal
Amputation
Arthroscopic Knee Surgery
Back Surgery
Carpal Tunnel Surgery
Cervical Spine Surgery
Disc Surgery
Foot Surgery
Hand Surgery
Hip Replacement
Hip Surgery
Knee Replacement
Knee Surgery
Leg Surgery
Rotator Cuff Surgery
Shoulder Surgery

Plastic
Breast Implants
Tummy Tuck

Respiratory
Lung Surgery

Skin
Basal Cell Carcinoma
Melanoma
Squamous Cell Carcinoma

Other: _____

_____

FAMILY HISTORY

Please CIRLCE and indicate which family member has/had any of the following:

(Mother, Father, Siblings, Grandmother, Grandfather, Uncle, Aunt)

Bedwetting _____
Bladder Cancer _____
Breast Cancer _____
Cancer (site unknown) _____
Crohn's Disease _____
Depression _____
Diabetes _____
Gout _____
Heart Attack _____
Hypertension _____
Kidney Cancer _____
Kidney Disease _____
Multiple Sclerosis _____
Stone Disease _____
Stroke _____
Thyroid Disease _____

Other: _____

_____