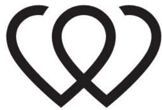

Women's Health Connecticut
Westwood Women's Health
Member of Women's Health Connecticut

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Name ______________________________ Date ______________

Referred by ______________________________ Birthdate ______________

Are you here for a problem? ☐ Yes ☐ No If yes, please describe it and how long you have had it.

____

____

____

Have you consulted anyone for this? ☐ Yes ☐ No

Who? (Name and Address) ______________________________

When? (Dates of treatment) ______________________________

Describe previous treatment ______________________________

GYN SYSTEM REVIEW:

Date of last period ______________________

Menses: Age at onset of period: ______________ Date of last pap smear ______________

☐ Irregular ☐ Regular

How often do you get your period? (Check appropriate box below)

☐ Less than 20 days apart ☐ 21 - 30 days apart ☐ 30 - 40 days apart ☐ Greater than 40 days apart

How many days do your periods generally last? (Check appropriate box below)

☐ Less than 2 ☐ 2 – 5 ☐ 5 – 7 ☐ 7 – 10 ☐ Greater than 10

How many pads do you use on heaviest days? ______________

Do you use ☐ Pads or ☐ Tampax Scented? ☐ Yes ☐ No

	YES	NO
Any clots?	____	____
How large? ______________		
Do you have to stay in bed on heavy days?	____	____
Do you miss work or school regularly each month?	____	____
If yes, how many days? ______________		
Any bleeding or spotting between periods?	____	____
Any bleeding or spotting after intercourse?	____	____

PAIN:

	YES	NO
Do you have any significant pain with periods?	____	____
Do you take any medication to relieve it regularly?	____	____
Do you have any lower abdominal pain at other times of the month?	____	____
Do you have pain during or after intercourse?	____	____
Do you have frequent headaches?	____	____

If yes to any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above answers:

____

____

____

____

____

DISCHARGE:

	YES	NO
Do you have any chronic or persistent discharge?	____	____
What color is it? ____________		
Does it have a bad odor?	____	____
Have you had itching?	____	____
Do you wear a pad for it?	____	____
Do you douche?	____	____
How often? ____________ What do you use? ____________		
Have you been treated for vaginitis before?	____	____
How many times? ____________		
Do you know what type? Trichomonoas Monilia Non-Specific		
When were you last treated? ____________		
What treatment did you receive? ____________		

G.U.

	YES	NO
Do you have or have you had recently:		
Burning on urination	____	____
Blood in urine	____	____
Undue frequency	____	____
Urgency about urinating	____	____
Do you get up at night to urinate?	____	____
How many times? ____________		
Do you wet yourself involuntarily with any of the following:		
coughing, sneezing, laughing, running, lifting or going up or down stairs?	____	____
Do you have a weak stream?	____	____
Were you a bed wetter as a child?	____	____
Have you had any bladder or kidney infections?	____	____
How many times? ________ When was the last one? ____________		
Have you ever had kidney x-rays?	____	____
Have you ever seen a urologist?	____	____

G.I.

	YES	NO
Are you chronically constipated?	____	____
Any change in bowel habit?	____	____
Do you take laxatives?	____	____
How often? ____________		
Do you have any blood in stools?	____	____
Do you have frequent or chronic diarrhea?	____	____
Any known ulcer?	____	____
Any known gall bladder disease?	____	____
Any other known intestinal or stomach disorder?	____	____

HABITS

	YES	NO
Do you smoke?	____	____
Number of cigarettes per day ____________		
Do you drink regularly?	____	____
How much per day? ____________		
Do you now or have you ever used coke, heroin, or marijuana?	____	____

OTHER:

	YES	NO
Have you had any of the following?		
Shortness of breath	____	____
Dizziness	____	____
Palpitations	____	____
Breast masses or lumps	____	____
Breast discharge	____	____
Problem with sexual function	____	____

BIRTH CONTROL:

METHOD	BRAND NAME	DATES OF USAGE	REASON FOR DISCONTINUATION
Birth Control Pills			
IUD			
Diaphram			
Foam			
Condoms			

PAST MEDICAL HISTORY (If yes, indicate dates, where treated and by whom beside each section)

Have you had:	YES	NO	
Rheumatic fever			
Rheumatic heart disease			
German measles			
Venereal disease			
Pneumonia			
High blood pressure			
Diabetes			
Tuberculosis			
Chronic kidney disease			
Anemia			
Hepatitis (yellow jaundice)			
Phlebitis			
Nervous breakdown			
Severe depression			
Epilepsy			
Migraine headaches			
Bleeding tendencies			
Psychiatric illness			
Thyroid disease			
Congenital heart disease			
Radiation therapy			
Other			

Describe previous YES answers:

SURGERY: List all surgical procedures you have had.

DATE APPROX	PROCEDURE	HOSPITAL	LOCATION	SURGEON

OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complications.

NO	MONTH/YEAR	INFANT SEX	WEIGHT AT BIRTH	WKS GEST	HOURS IN LABOR	TYPE OF DELIVERY	ANESTHESIA	COMMENTS/COMPLICATIONS
1								
2								
3								
4								
5								
6								
7								

ALLERGIES:

Are you allergic to any drugs or medication? ☐ Yes ☐ No

List drug ______________________ Type of reaction ______________________________________

______________________ ______________________________________

Do you have hay fever or asthma? ☐ Yes ☐ No

If yes, what treatments do you take? ______________________________________

____

MEDICATIONS:

List all medications presently being taken, if any

DRUG	REASON	HOW LONG TAKEN	ANY SIDE EFFECTS

Have you been hospitalized for anything else not discussed?

DATE	HOSPITAL	REASON FOR ADMISSION	DURATION OF STAY

FAMILY HISTORY:

	AGE	STATE OF HEALTH	SPECIFIC AILMENTS	IF DECEASED, AGE AT DEATH & CAUSE
MOTHER				
FATHER				
BROTHER				
BROTHER				
SISTER				
SISTER				

History of any of the following in grandparents, uncles, aunts, relatives and list relationship:

Breast Cancer ____

Diabetes ____

Uterine Cancer ____

Rectal or colon cancer ____

Other Familial diseases: ____

If there is any other pertinent medical information not previously mentioned, please discuss:

____

____

____

____

____