

Women Gynecology & Childbirth Associates, P.C.

Date _____ SS # _____

Legal Name _____ Date of Birth _____ Age _____
First M Last

Phone number: (home) _____ (work) _____ (cell) _____

E-mail address: _____

Occupation _____ Name of your internist/family Dr.: _____

Other frequently seen health care providers: _____

Last menstrual period, if applicable _____

Current method of birth control (including tubal ligation and/or vasectomy), if applicable _____

Current Medications: _____

Vitamins/Herbs: _____

Please list any Medication allergies _____

Are you allergic to Latex? _____

Any changes in your medical history since last visit?:

Surgeries _____	Osteoporosis _____
Births _____	High Cholesterol _____
Illness _____	Thyroid disease _____
Injury _____	Cancer _____
Other _____	

Any changes in family medical history since last visit?:

Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no	Stroke <input type="checkbox"/> yes <input type="checkbox"/> no	High Cholesterol <input type="checkbox"/> yes <input type="checkbox"/> no
Breast Cancer <input type="checkbox"/> yes <input type="checkbox"/> no	Thyroid Disease <input type="checkbox"/> yes <input type="checkbox"/> no	High Blood Pressure <input type="checkbox"/> yes <input type="checkbox"/> no
Cancer (other) <input type="checkbox"/> yes <input type="checkbox"/> no	Clotting/Bleeding Disorder <input type="checkbox"/> yes <input type="checkbox"/> no	Osteoporosis <input type="checkbox"/> yes <input type="checkbox"/> no
Ovarian Cancer <input type="checkbox"/> yes <input type="checkbox"/> no	Heart Disease <input type="checkbox"/> yes <input type="checkbox"/> no	Deaths <input type="checkbox"/> yes <input type="checkbox"/> no
Colon Cancer <input type="checkbox"/> yes <input type="checkbox"/> no		Who Died? _____
Other _____		When? _____

Social History and Preventative Health:

Date of last mammogram _____ Date of last PAP _____ Date of last Pelvic Exam _____

Have you completed a Health Care Proxy? yes no

Have you experienced domestic violence? (physical, verbal, sexual abuse) yes no

Have you had colon cancer screening? (stool blood, sigmoidoscopy, colonoscopy) yes no
When was last done? _____

Have you had a Hepatitis B vaccine? (recommended for health care workers & those under 15) yes no

Have you had a Tetanus shot within last 10 years? yes no

Have you had chickenpox or the vaccine? yes no

Have you had Measles-Mumps-Rubella vaccine? (under 45) yes no

Have you had pneumonia vaccine (over 65) yes no

HPV vaccine is now available for women ages 9 – 26. Do you wish information? yes no

Have you already had the HPV vaccine series? (age 9-26) yes no

Do you wear a seat belt? yes no

Do you smoke tobacco? yes no

Do you do drugs? yes no

Do you have body piercing (other than ears)? yes no

Do you have tattoos? yes no

How recently were they done? _____

Are you currently sexually active? yes no

Do you practice safe sex? yes no

_____ male partner _____ female partner

Do you wish HIV testing? yes no

Do you do Self Breast Exams? yes no

Have you had exposure to Hepatitis? yes no

Do you drink alcohol? yes no

Do you follow a special diet? yes no

Do you eat a balanced diet? yes no

Do you exercise? yes no

How often? _____

Do you see a dentist regularly? yes no

What are you using for sun protection? _____

Do you drink caffeine? yes no

Do you take Calcium? yes no

Have you had your Cholesterol checked? yes no

When was this last done? _____

Have you had a bone density test (DXA scan)? yes no

When was last done? _____

REVIEW OF SYSTEMS

Do you **NOW** have problems with: **(ANSWER YES ONLY IF PROBLEM IS CURRENT)**

Lost weight	<input type="checkbox"/> yes <input type="checkbox"/> no	Heavy vaginal bleeding	<input type="checkbox"/> yes <input type="checkbox"/> no
Gained weight	<input type="checkbox"/> yes <input type="checkbox"/> no	# of pads per day _____	
Fever	<input type="checkbox"/> yes <input type="checkbox"/> no	Bleeding between periods	<input type="checkbox"/> yes <input type="checkbox"/> no
Fatigue	<input type="checkbox"/> yes <input type="checkbox"/> no	Painful periods	<input type="checkbox"/> yes <input type="checkbox"/> no
Vision changes	<input type="checkbox"/> yes <input type="checkbox"/> no	Prolonged periods (more than 9 days)	<input type="checkbox"/> yes <input type="checkbox"/> no
Glaucoma	<input type="checkbox"/> yes <input type="checkbox"/> no	Pain with intercourse	<input type="checkbox"/> yes <input type="checkbox"/> no
Headaches	<input type="checkbox"/> yes <input type="checkbox"/> no	Bleeding with intercourse	<input type="checkbox"/> yes <input type="checkbox"/> no
Environmental allergies	<input type="checkbox"/> yes <input type="checkbox"/> no	Unusual vaginal discharge, odor or itching?	<input type="checkbox"/> yes <input type="checkbox"/> no
Sinusitis	<input type="checkbox"/> yes <input type="checkbox"/> no	Vaginal dryness	<input type="checkbox"/> yes <input type="checkbox"/> no
Chest pain	<input type="checkbox"/> yes <input type="checkbox"/> no	Breast lump	<input type="checkbox"/> yes <input type="checkbox"/> no
Irregular heartbeat	<input type="checkbox"/> yes <input type="checkbox"/> no	Fibrocystic breasts	<input type="checkbox"/> yes <input type="checkbox"/> no
High blood pressure	<input type="checkbox"/> yes <input type="checkbox"/> no	Breast discharge	<input type="checkbox"/> yes <input type="checkbox"/> no
Blood clot in legs	<input type="checkbox"/> yes <input type="checkbox"/> no	Breast pain	<input type="checkbox"/> yes <input type="checkbox"/> no
Wheezing / asthma	<input type="checkbox"/> yes <input type="checkbox"/> no	Breast rash	<input type="checkbox"/> yes <input type="checkbox"/> no
Shortness of breath	<input type="checkbox"/> yes <input type="checkbox"/> no	Depression	<input type="checkbox"/> yes <input type="checkbox"/> no
Persistent cough	<input type="checkbox"/> yes <input type="checkbox"/> no	Stress/Anxiety	<input type="checkbox"/> yes <input type="checkbox"/> no
Nausea/vomiting	<input type="checkbox"/> yes <input type="checkbox"/> no	Moodiness/PMS	<input type="checkbox"/> yes <input type="checkbox"/> no
Diarrhea	<input type="checkbox"/> yes <input type="checkbox"/> no	Hot flashes or night sweats	<input type="checkbox"/> yes <input type="checkbox"/> no
Bloody stool	<input type="checkbox"/> yes <input type="checkbox"/> no	Painful joints	<input type="checkbox"/> yes <input type="checkbox"/> no
Abdominal pain	<input type="checkbox"/> yes <input type="checkbox"/> no	Muscle weakness or pain	<input type="checkbox"/> yes <input type="checkbox"/> no
Bloating/excessive gas	<input type="checkbox"/> yes <input type="checkbox"/> no	Backache	<input type="checkbox"/> yes <input type="checkbox"/> no
Urinary incontinence	<input type="checkbox"/> yes <input type="checkbox"/> no	Anemia (low blood)	<input type="checkbox"/> yes <input type="checkbox"/> no
Overactive bladder	<input type="checkbox"/> yes <input type="checkbox"/> no	Swollen lymph nodes	<input type="checkbox"/> yes <input type="checkbox"/> no
Other urinary problems (explain below)	<input type="checkbox"/> yes <input type="checkbox"/> no	Bleeding gums	<input type="checkbox"/> yes <input type="checkbox"/> no
		Skin rash	<input type="checkbox"/> yes <input type="checkbox"/> no
Fecal (rectal) incontinence	<input type="checkbox"/> yes <input type="checkbox"/> no	Fainting	<input type="checkbox"/> yes <input type="checkbox"/> no
Thyroid problem	<input type="checkbox"/> yes <input type="checkbox"/> no	Seizures / Epilepsy	<input type="checkbox"/> yes <input type="checkbox"/> no
Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	Numbness	<input type="checkbox"/> yes <input type="checkbox"/> no
Sexual dysfunction	<input type="checkbox"/> yes <input type="checkbox"/> no	Weakness	<input type="checkbox"/> yes <input type="checkbox"/> no
(this may require a separate consultation visit)		Trouble walking	<input type="checkbox"/> yes <input type="checkbox"/> no
		Do you have any aesthetic concerns (i.e. hair, skin)?	<input type="checkbox"/> yes <input type="checkbox"/> no
		If so what are they? _____	

Problems or special issues to be discussed with care provider today: _____

Guidelines from our Medical Malpractice Insurance carrier require all providers, regardless of gender, to offer a chaperone for any appointment that includes a breast or genital exam. Although we have had no previous issues, we are happy to provide this service.

Would you like a chaperone during your visit today? yes no

I am aware of WGCA's Protected Health Information (PHI) Policy.

SIGNED BY PATIENT

Signed by Provider