ASSOCIATES FOR WOMEN'S HEALTH *INITIAL PATIENT HISTORY FORM*

*please complete all parts of this sheet before you see the provider

PHYSICIAN (please circle): Asdell, Boyer, Jain

PATIENT'S NAME:____DOB:________AGE:______

Phone Numbers (home)_________________ (work)______________SS#___________________

Reason for Appointment:

Condition	Have you had?	Family? / Which Member?
Diabetes	Y N	
High Blood Pressure	Y N	
Epilepsy / Convulsions	Y N	
Frequent severe headaches	Y N	
Sickle Cell	Y N	
Heart Disease / Heart Attack(s)	Y N	
Stroke	Y N	
Breast Cancer	Y N	
Colon Cancer	Y N	
Ovarian Cancer	Y N	
Other Cancer (which):		

Condition	Have you had? / When? / Treatment
Thyroid Disease	Y N
Breast mass (lumps) or discharge	Y N
Asthma	Y N
TB or other lung condition	Y N
Heart murmurs or MVP	Y N
Rheumatic fever	Y N
Stomach / Intestinal problems	Y N
Hepatitis, Mono, or liver problems	Y N
Gall bladder disease	Y N
Sexually transmitted diseases	Y N
Frequent vaginal infections	Y N
Infection of uterus, tubes, or ovaries	Y N
Tumors	Y N
Blood clots in veins / clotting disorder	Y N
Varicose veins	Y N
Anemia (low blood count)	Y N
Rubella (German measles or 3 day measles)	Y N
Immunizations / Vaccinations	Y N
Mental / Emotional problems	Y N
Other:	

Physician reviewed:____________________________________ Date:_______________

***Name*_____________________*Date of birth*____________________**

Review of Systems:

Condition	***Do you currently have***	***Have you had in past***	***Notes***
CONSTITUTIONAL:			
Weight loss			
Weight gain			
Fever			
Fatigue			
EYES:			
Double Vision			
Spots before eyes			
Vision changes			
ENT / MOUTH:			
Ear aches			
Ringing in ears			
Sinus problems			
Sore throat			
Mouth sores			
Dental problems			
CARDIOVASCULAR:			
Painful breathing			
Chest pain			
Difficulty breathing			
Swelling of legs			
Heart palpitations			
RESPIRATORY:			
Wheezing			
Spitting up blood			
Shortness of breath			
Chronic cough			
GASTROINTESTINAL:			
Frequent diarrhea			
Bloody stool			
Nausea / vomiting			
Constipation			
GENITOURINARY:			
Blood in urine			
Painful urination			
Urgency			
Urinary frequency			
Incomplete emptying			
Stress incontinence			
Abnormal periods			
Painful intercourse			

Physician reviewed:______________________________________ Date:_______________

***Name*____________________*Date of birth*____________________**

Condition	***Do you currently have***	***Have you had in past***	***Notes***
MUSCULOSKELETAL:			
Muscle weakness			
SKIN / BREAST:			
Pain in breast			
Nipple discharge			
Masses			
Rash			
Ulcers			
NEUROLOGICAL:			
Dizziness			
Seizures			
Numbness			
Trouble walking			
PSYCHIATRIC:			
Depression			
Crying frequently			
ENDOCRINE:			
Dry skin			
Abnormal thirst			
Hot flashes			
HEMATOLOGICAL:			
Frequent bruises			
Cuts that do not stop bleeding			
Enlarged lymph node			

Please list any/all medications you are currently taking (including over the counter):

____
____
____

ALLERGIES:

Do you drink alcohol? Y N How much?___________________________________
Do you smoke? Y N How much?___________________________________
Do you use drugs? Y N What?/How much?_____________________________
Do you exercise? Y N What?/How much?_____________________________
Have you ever had a mammogram? Y N When?__________________________
Have you ever had a pelvic exam? Y N
Date of last pap smear____________________ Normal / Abnormal Where?________________
Have you ever had an abnormal pap smear? Y N
Treatment/Date____
Do you douche/use feminine hygiene products? Y N How often?________________

Physician reviewed:_______________________________________ Date:_______________

***Name*___________________*Date of birth*_______________________**

Please list any surgeries you have had (inpatient and outpatient) as well as the date done:

____
____
____
____

PREGNANCY HISTORY:

Have you ever been pregnant? Y N (If yes, please complete this section)

Total number of pregnancies: __________ *Number of stillbirths:* __________
Number of live births: __________ *Number of living children:* __________
Number of miscarriages: __________ *Have you ever had a tubal preg?* __________
Number of elective abortions: __________ *Your age at your first pregnancy:* __________
Number of vaginal deliveries: __________ *Number of C-Sections:* __________

Have you ever had any complications with pregnancy or labor and delivery? Y N
Explain:____

MENSTRUAL HISTORY:

Date of your last menstrual period (first day): ______________________________
How old were you when you started your first period? ______________________________
Do you have a period every month? Y N
Interval (number of days from the start of one period to the start of the next): ______________________________
Number of days of flow / bleeding: ______________________________
Do you have any of the following:

Cramps	Y	N	Vaginal sores	Y	N
Discharge	Y	N	Bleeding w/intercourse	Y	N
Vaginal odor	Y	N	Painful intercourse	Y	N

CONTRACEPTIVE HISTORY:

Have you ever used any thing or system to keep you from getting pregnant? Y N
What methods have you used in the past? (check all that apply)

___Withdrawal (pulling out)	___Vaginal sponge	___Vasectomy
___Oral (the pill)	___Rhythm (calendar)	___Abstinence
___IUD (type:__________)	___Condoms	___"luck"
___Diaphragm	___Injections (shot)	___Natural family planning
___Foam, jelly, cream	___Tubal ligation	___Other:______________

What method are you currently using?____
How long have you been using this method?____
What method do you want to use now?____
Age at your first sexual intercourse?___________ Total # of sexual partners:______________
Are you trying to get pregnant? Y N For how long?________________________

____ _____________________

PATIENT SIGNATURE DATE

Physician reviewed:_________________________________ Date:______________