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	__yes	__no	Stroke	__yes	__no	High Cholesterol	__yes	__no
Breast Cancer	__yes	__no	Thyroid Disease	__yes	__no	High Blood Pressure	__yes	__no
Cancer (other)	__yes	__no	Clotting/Bleeding Disorder	__yes	__no	Osteoporosis	__yes	__no
Ovarian Cancer	__yes	__no	Heart Disease	__yes	__no	Deaths	__yes	__no
Colon Cancer	__yes	__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 ó 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? _________________		

Name ____________________________________

REVIEW OF SYSTEMS

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

Lost weight	__yes	__no
Gained weight	__yes	__no
Fever	__yes	__no
Fatigue	__yes	__no
Vision changes	__yes	__no
Glaucoma	__yes	__no
Headaches	__yes	__no
Environmental allergies	__yes	__no
Sinusitis	__yes	__no
Chest pain	__yes	__no
Irregular heartbeat	__yes	__no
High blood pressure	__yes	__no
Blood clot in legs	__yes	__no
Wheezing / asthma	__yes	__no
Shortness of breath	__yes	__no
Persistent cough	__yes	__no
Nausea/vomiting	__yes	__no
Diarrhea	__yes	__no
Bloody stool	__yes	__no
Abdominal pain	__yes	__no
Bloating/excessive gas	__yes	__no
Urinary incontinence	__yes	__no
Overactive bladder	__yes	__no
Other urinary problems (explain below)	__yes	__no
Fecal (rectal) incontinence	__yes	__no
Thyroid problem	__yes	__no
Diabetes	__yes	__no
Sexual dysfunction	__yes	__no

(this may require a separate consultation visit)

Heavy vaginal bleeding	__yes	__no
# of pads per day _________		
Bleeding between periods	__yes	__no
Painful periods	__yes	__no
Prolonged periods (more than 9 days)	__yes	__no
Pain with intercourse	__yes	__no
Bleeding with intercourse	__yes	__no
Unusual vaginal discharge, odor or itching?	__yes	__no
Vaginal dryness	__yes	__no
Breast lump	__yes	__no
Fibrocystic breasts	__yes	__no
Breast discharge	__yes	__no
Breast pain	__yes	__no
Breast rash	__yes	__no
Depression	__yes	__no
Stress/Anxiety	__yes	__no
Moodiness/PMS	__yes	__no
Hot flashes or night sweats	__yes	__no
Painful joints	__yes	__no
Muscle weakness or pain	__yes	__no
Backache	__yes	__no
Anemia (low blood)	__yes	__no
Swollen lymph nodes	__yes	__no
Bleeding gums	__yes	__no
Skin rash	__yes	__no
Fainting	__yes	__no
Seizures / Epilepsy	__yes	__no
Numbness	__yes	__no
Weakness	__yes	__no
Trouble walking	__yes	__no

Do you have any aesthetic concerns (i.e. hair, skin)?___yes __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 WGCAøs Protected Health Information (PHI) Policy.

____________________________________ ________________________________

SIGNED BY PATIENT Signed by Provider