

Women Gynecology & Childbirth Associates, P.C.
PATIENT HISTORY

Name: _____ Date of Birth: _____ Today's Date: _____
Name you prefer to be called: _____
Age: _____ Preferred Pharmacy: _____
Primary care doctor: _____

What is the reason for your appointment today?
 Yearly Exam/Pap smear
 Other: _____

What questions do you have for your health care provider today?

Which prescriptions do you need refilled today?

List all medications/vitamins that you are taking:

Please list all medications you are ALLERGIC to:

When was your last menstrual period (LMP): _____ # of Pregnancies _____

When was your last ----? List the year.
Pap smear: _____
Tetanus shot: _____
Mammogram (if over 40 years old) _____
Colonoscopy (if over 50 years old) _____
Bone Density (if in menopause) _____
Cholesterol check (if over 40 years old) _____

Do you want an HIV test? No Yes Other STD testing? No Yes
Do you have a health care proxy? No Yes

Are you having any CURRENT problems with -----? (Please circle those that apply-ONLY IF CURRENT)

General: weight gain weight loss fatigue fever
HEENT: headache bleeding gums blurry vision
CV: chest pain palpitations irregular heart beat
Resp: cough shortness of breath wheezing
GI: nausea vomiting abdominal pain diarrhea constipation unusual bloating rectal bleeding
GU: pain with urination incontinence frequent urination abnormal vaginal discharge pelvic pain
Musculoskeletal: swelling in joints pain in joints
Skin: rash change in moles abnormal lumps/bumps
Breast: breast pain spontaneous nipple discharge skin changes breast lump
Neurologic: fainting numbness weakness
Psychiatric: depression anxiety poor sleep impaired memory other mood changes
Endocrine: sweating increased thirst increased urination
Heme: easy bruising easy bleeding
If menopausal: night sweats hot flashes vaginal dryness poor sleep

Would you like a chaperone today? We would be happy to provide one. No Yes

**Due to numerous changes by insurance companies, you may be financially responsible for the lab tests and additional services provided at your visit today. Patient Signature: _____ Date: _____