

Health Care for Women, PA
Patient Information / History Form

Patient Name: _____ Date _____

Reason for Visit: _____ Annual Physical

PAP HISTORY:

Date of last pap smear: _____ Normal / Abnormal

BREAST IMAGING:

Date of last mammogram or breast ultrasound: _____ Normal / Abnormal

Location: _____

Date of Last Period _____ Hysterectomy - Yes No Menopause # of years _____

Pain with ovulation:	Yes	No	N/A
PMS symptoms:	Yes	No	N/A
Period:	Regular	Irregular	N/A
Average length of bleeding:	# _____ of days		N/A
Flow:	Heavy	Moderate	Light
Pain with Period:	Yes	No	N/A
Pain with intercourse:	Yes	No	N/A

Menopausal Symptoms: N/A, none, hot flashes, vaginal dryness, mood swings, insomnia, bleeding

Leakage: Urine Stool

Contraception: none, N/A, pill, condom, Depo Provera, patch, vasectomy, tubal, diaphragm, foam, IUD, rhythm

Desire Future Children: YES NO UNSURE

OBSTETRIC HISTORY:

of pregnancies _____ # of deliveries _____ Miscarriage _____ Abortion _____

Vaginal delivery (#) _____ C-Section delivery (#) _____ Weight of largest baby: _____ lbs _____ oz

Complications: _____

GYNECOLOGIC SURGERIES DATE (month/year):

(Ex: tubal ligation, laparoscopy, cone biopsy, leep, hysterectomy, bladder surgery, breast augmentation or reduction, D&C, ectopic pregnancy, abortion etc.)

1. ____/____/____ 2. ____/____/____
3. ____/____/____ 4. ____/____/____
5. ____/____/____ 6. ____/____/____

NON-GYNECOLOGIC SURGERIES DATE (month/year):

(Ex: tonsils, appendix, hemorrhoids, back, thyroid, colonoscopy, plastic surgery, etc.)

1. ____/____/____ 2. ____/____/____
3. ____/____/____ 4. ____/____/____
5. ____/____/____ 6. ____/____/____

Injuries, Traumas, Broken bones: None / Date _____

Blood Transfusions: None / Date _____

MEDICAL HISTORY, DATE OF DIAGNOSIS AND MANAGING DOCTOR:

(Ex: thyroid, depression, high blood pressure, high cholesterol, heart problems, obesity, etc.)

- 1. _____ 2. _____
- 3. _____ 4. _____
- 5. _____ 6. _____

History of Herpes, HPV, Chlamydia, Gonorrhea, Syphilis, HIV, Genital Warts: Yes No

Primary Care Physician / Internist: _____

Immunizations: Up to Date: _____ unsure _____

Medication allergies: _____

CURRENT MEDICATIONS:

Start Date:	Medication and dosage	# per day	Indicate if 30 or 90 day	Need refill
___/___/___	_____	_____	_____	Yes / No
___/___/___	_____	_____	_____	Yes / No
___/___/___	_____	_____	_____	Yes / No
___/___/___	_____	_____	_____	Yes / No
___/___/___	_____	_____	_____	Yes / No
___/___/___	_____	_____	_____	Yes / No
___/___/___	_____	_____	_____	Yes / No

Over the Counter Medications: _____

SOCIAL HISTORY:

Marital Status: Married, single, divorced, widowed, other: _____

Live with: Alone, spouse, family, parents, pets, roommate, other: _____

Sexually Active: YES NO (Abstinent Virgin). # of partners over lifetime _____

Supplements currently taking: multi vitamins, C, E, Calcium, B complex, other: _____

Drug use in past: YES NO Decline answering question. Current drug use: YES NO Social

Smoker: YES # packs per day ___ social NO QUIT (# of years ago ___)

Alcohol: SOCIAL NONE AA Decline answering question

FAMILY HISTORY: Please indicate which family member

- Breast Cancer _____ Cancer _____ Colon Cancer _____ Cholesterol _____
- Diabetes _____ Depression _____ Heart Disease _____
- High Blood pressure _____ Osteoporosis _____ Stroke _____ other _____

I request the following tests: Blood Work Mammogram Bone Densitometry
Gonorrhea Chlamydia Pregnancy Test

Pharmacy name & phone number: _____