

Phoenix Women's Center, P.C.

NAME: _____ DATE: ___ / ___ / ___ BIRTHDATE: ___ / ___ / ___

NAME PREFERRED TO BE CALLED: _____ AGE: _____

REFERRED BY: _____

REASON FOR VISIT: ROUTINE GYN CARE PROBLEM DESCRIBE PROBLEM: _____

CHECK IF YOU HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST:

MAJOR ILLNESSES	YES	NO	MAJOR ILLNESSES	YES	NO
Anemia			Hepatitis / Jaundice		
Anxiety			Herpes / HSV		
Arthritis / Joint pain			High Blood Pressure		
Asthma			High Cholesterol		
Blood transfusions			HIV / AIDS		
Bowel Trouble			HPV / Human Papilloma Virus		
Breast Cancer			Kidney Infections / Urinary Tract Infections		
Cancer			Kidney Stones		
Chicken Pox			Mood Disorders		
Chlamydia			Pneumonia		
Chronic Lung Disease			Rheumatic Fever		
Depression			Sexually Transmitted Diseases		
Diabetes			Stroke		
Eating Disorder			Syphilis		
Fracture			Tuberculosis - TB		
Glaucoma			Thyroid Disease		
Gonorrhea / GC			Ulcers		
Heart Murmur			OTHER:		
Heart Trouble					

WHEN WAS YOUR LAST TEST OR IMMUNIZATION?

	DATE		DATE
Bone Density		Mammogram	
Colonoscopy / Sigmoidoscopy		TB Skin Test	
Flu Shot		Last Normal PAP Smear	
Pneumonia		Last Abnormal PAP Smear	
Tetanus			

PLEASE LIST ANY PAST INJURIES OR ILLNESSES:

TYPE	DATE	TYPE	DATE

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:

SURGERY / HOSPITALIZATION / REASON	DATE	SURGERY / HOSPITALIZATION / REASON	DATE

NAME: _____

BIRTHDATE: ____ / ____ / ____

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

DRUG NAME	DOSAGE	PHYSICIAN	DRUG NAME	DOSAGE	PHYSICIAN
ALLERGIES TO MEDICATIONS / SUBSTANCES (LATEX GLOVES, ETC.?)		List:			

CIRCLE AND CHECK IF YOUR BLOOD RELATIVES HAVE HAD:

MAJOR ILLNESSES	YES	NO	WHAT BLOOD RELATIVE? Mother's / Father's
Anemia			
Arthritis / Joint pain			
Asthma			
Bowel Trouble / Ulcers			
Breast Cancer			
Cancer			
Chronic Lung Disease			
Depression / Anxiety / Mood Disorders			
Diabetes			
Glaucoma			
Heart Trouble / Murmur			
Hepatitis / Jaundice			
High Blood Pressure			
High Cholesterol			
Kidney Infections / Stones			
Stroke			
Thyroid Disease			
Tuberculosis - TB			
OTHER:			

NAME: _____ BIRTHDATE: ____ / ____ / ____

YOUR GYN HISTORY

Are you currently using or have ever used any birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Condoms	<input type="checkbox"/> Nuvaring
<input type="checkbox"/> Depo Provera	<input type="checkbox"/> Birth Control Patch
<input type="checkbox"/> Diaphragm	<input type="checkbox"/> None
<input type="checkbox"/> IUD- Kind	<input type="checkbox"/> Natural Family Plan/Rhythm
- Date Inserted:	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Birth Control Pill	<input type="checkbox"/> Vasectomy
- Name:	<input type="checkbox"/> Withdrawal
<input type="checkbox"/> Contraceptive Foam/Jelly	<input type="checkbox"/> Other:
What age did you have your first period: _____	
How many days are there from start of your period to start of next period? _____ days	
How long does your period last? _____ days	Flow: <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy
Date of Last Period: _____	Are you sure of the date? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was it a normal period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had recent abnormal bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No When: _____

YOUR OB HISTORY

	NUMBER		NUMBER
Total # of pregnancies		Full term births	
Premature delivery (less than 37 weeks)		Abortions / Termination	
Miscarriages		Living children	

On the chart below, please fill in answers for each pregnancy including abortions or miscarriages.

No.	Birth Date	Wks Gest	Labor (hrs)	Baby's Weight/Sex	Del Type Vag/CSection	Epid Y / N	Preterm Labor?	Wt Gain	Comments / Complications	Hospital
1				M						
				F						
2				M						
				F						
3				M						
				F						
4				M						
				F						
5				M						
				F						
6				M						
				F						

What are some of the questions you would like answered today?

NAME: _____ BIRTHDATE: ____ / ____ / ____

SOCIAL HISTORY

Do you do a Self Breast Exam? <input type="checkbox"/> Yes <input type="checkbox"/> No		How often: _____
Do you Drink Milk? <input type="checkbox"/> Yes <input type="checkbox"/> No Glasses per day: _____		
Do you Eat Cheese or other Dairy products? <input type="checkbox"/> Yes <input type="checkbox"/> No Servings per day: _____		
Do you Take Calcium? <input type="checkbox"/> Yes <input type="checkbox"/> No Name and Dosage: _____		
Do you Exercise? <input type="checkbox"/> None <input type="checkbox"/> Less than 3 times per week <input type="checkbox"/> More than 3 times per week		
Do you have sex with? <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both		
First Intercourse at Age: _____ New sexual partner? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Lifetime sexual partners <input type="checkbox"/> Less than 5 <input type="checkbox"/> More than 5		
Smoking <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously Packs per day: _____ Number of Years: _____ Stopped _____ Years ago		
Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously Drinks per day: _____ Drink per week: _____		
Drug User <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously Kind: _____ Frequency: _____		
History of abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Physical <input type="checkbox"/> Emotional <input type="checkbox"/> Sexual		
List all "Natural" or Herbal remedies, over the counter drugs, vitamins or minerals you are taking.	List: _____	
Occupation: _____		
Race <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other _____		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		

NAME: _____

BIRTH DATE: ____/____/____

REVIEW OF SYSTEMS:
Please Check (X) If Any Of The Following Applies To You NOW.

CONSTITUTIONAL	NOTES	GENITOURINARY (CONT)	NOTES
Weight Loss <input type="checkbox"/>		Decreased sex drive <input type="checkbox"/>	
Weight Gain <input type="checkbox"/>		Painful intercourse <input type="checkbox"/>	
Fever <input type="checkbox"/>		Possible Pregnancy <input type="checkbox"/>	
Fatigue <input type="checkbox"/>		Genital Sores <input type="checkbox"/>	
Night Sweats <input type="checkbox"/>			
Hot Flashes <input type="checkbox"/>		SKIN	
EYES		Rashes <input type="checkbox"/>	
Double vision <input type="checkbox"/>		Itching <input type="checkbox"/>	
Vision changes <input type="checkbox"/>		Skin Dryness <input type="checkbox"/>	
HENT		Skin Lesions <input type="checkbox"/>	
Headaches <input type="checkbox"/>		Changes to Lesions or Moles <input type="checkbox"/>	
Dizziness <input type="checkbox"/>		Acne <input type="checkbox"/>	
Sore Throat <input type="checkbox"/>			
Sinus Pain <input type="checkbox"/>		NEUROLOGICAL	
Nose Bleeding <input type="checkbox"/>		Muscular Weakness <input type="checkbox"/>	
Thyroid Mass <input type="checkbox"/>		Numbness or Tingling <input type="checkbox"/>	
Neck Pain <input type="checkbox"/>		Difficulty Concentrating <input type="checkbox"/>	
BREAST		Memory Difficulties <input type="checkbox"/>	
Lumps <input type="checkbox"/>		Speech Difficulties <input type="checkbox"/>	
Tenderness <input type="checkbox"/>		Seizures <input type="checkbox"/>	
Swelling <input type="checkbox"/>		Loss of Balance <input type="checkbox"/>	
Discharge <input type="checkbox"/>			
Pain in Breast <input type="checkbox"/>		MUSCULOSKELETAL	
Abn Changes in Breast <input type="checkbox"/>		Joint Pain or Swelling <input type="checkbox"/>	
		Muscle Pain <input type="checkbox"/>	
CARDIOVASCULAR		Back Pain <input type="checkbox"/>	
Chest Pain <input type="checkbox"/>			
Irregular Heart Beats <input type="checkbox"/>		ENDOCRINE	
Rapid Heart Rate <input type="checkbox"/>		Loss of Hair <input type="checkbox"/>	
Fainting <input type="checkbox"/>		Difficulty Tolerating Cold <input type="checkbox"/>	
Swelling of legs <input type="checkbox"/>		Difficulty Tolerating Heat <input type="checkbox"/>	
Varicose veins <input type="checkbox"/>			
RESPIRATORY		PSYCHIATRIC	
Wheezing <input type="checkbox"/>		Anxiety <input type="checkbox"/>	
Cough <input type="checkbox"/>		Depression <input type="checkbox"/>	
Shortness of breath <input type="checkbox"/>		Impulsive Behavior <input type="checkbox"/>	
Spitting up blood <input type="checkbox"/>		Suicidal Thoughts <input type="checkbox"/>	
GASTROINTESTINAL		Excessive Anger <input type="checkbox"/>	
Nausea <input type="checkbox"/>		Mood Swings <input type="checkbox"/>	
Vomiting <input type="checkbox"/>		Emotional Abuse <input type="checkbox"/>	
Diarrhea <input type="checkbox"/>		Physical Abuse <input type="checkbox"/>	
Constipation <input type="checkbox"/>		Sexual Abuse <input type="checkbox"/>	
Abdominal Pain <input type="checkbox"/>		HEMATOLOGIC/ LYMPHATIC	
Bloody / Black Stool <input type="checkbox"/>		Bruises, frequent or easily <input type="checkbox"/>	
Hemorrhoids <input type="checkbox"/>		Cuts do not stop bleeding <input type="checkbox"/>	
Jaundice <input type="checkbox"/>		Enlarged lymph nodes <input type="checkbox"/>	
GENITOURINARY		ALLERGIC/IMMUNOLOGIC	
Urgency of urination <input type="checkbox"/>		Frequent illness <input type="checkbox"/>	
Frequency of urination <input type="checkbox"/>		Seasonal Allergies <input type="checkbox"/>	
Pain with urination <input type="checkbox"/>		OTHER	
Nighttime urination <input type="checkbox"/>		1. <input type="checkbox"/>	
Losing urine <input type="checkbox"/>		2. <input type="checkbox"/>	
Blood in urine <input type="checkbox"/>		3. <input type="checkbox"/>	