



Name _____ Date: _____ Date of Birth* _____
 Age _____ Race* _____ Ethnicity* _____ Primary Language* _____
 *Required by Healthcare/Meaningful Use Legislation.

Well Woman Update: (Please provide dates where applicable) Primary Care Provider (Doctor): _____

Last bone density exam _____(year) Any abnormal Pap smears? _____YES____NO
 Last colonoscopy _____(year) Cervical Dysplasia (precancerous cells of the cervix)?
 Last mammogram _____(year) _____YES____NO
 Last Pap smear _____(month/year) If yes, any treatment? Dates:
 LEEP _____
 Last tetanus shot _____(year) Laser _____
 HPV/ Gardasil Vaccine series completed? ____ YES __ NO Cryo (freezing) _____
 Have you had the Hepatitis B series? ____ YES __ NO Cone Biopsy _____

Medical History: Do you now have or have you ever had:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Diabetes Type I | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Migraines |
| _____ | <input type="checkbox"/> Diabetes Type II | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Elevated cholesterol | <input type="checkbox"/> Herpes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Infertility | <input type="checkbox"/> Pelvic inflamm. disease |
| <input type="checkbox"/> Bone/Joint Disease | <input type="checkbox"/> Fibroids (type?) _____ | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer (type?) _____ | <input type="checkbox"/> GERD/Reflux | <input type="checkbox"/> HIV | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> G.I. illness _____ | <input type="checkbox"/> HPV/genital warts | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chicken pox vaccination | <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hypothyroidism | |

Other: _____

Surgical History: Please list ALL surgical procedures, including year:

Medicines & Allergies:
 Current medications & dosage _____

 Vitamins/herbal supplements _____
 Drug allergies _____
 Reaction _____

Family History: Include the age of onset and type of cancer.

ILLNESS	Mother	Father	Brother	Sister	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Other relative
Cancer (type)									
Diabetes (type)									
Psychiatric									
Hypertension									
Blood Clots									
Osteoporosis									
Other									

Reproductive History: Menstrual Cycle

Age at first period? _____ Day of last period: _____ If menopausal, age of menopause: _____

How often do you get your menstrual cycle? Every _____ days, lasting _____ days.

Are your cycles? Regular Irregular
Are you sexually active? Never Not currently Yes

Method of contraception:

 Not Needed Vasectomy Rhythm Method Implanon Tubal Ligation
 None Condoms NuvaRing Mirena IUD Essure
 Pill Patch Depo Provera ParaGuard IUD Other _____**Obstetrical History**

Please list all pregnancies, including miscarriages, abortions, and ectopic pregnancies. Please include full birthdate.

Type: vaginal, C/S, forceps, or vacuum **Anesthesia:** epidural, local, general, spinal**Complications:** EXAMPLES: preterm labor, diabetes, bleeding, high blood pressure, postpartum depression.
If preterm labor, were medications used?**PAST PREGNANCIES**

	Birthdate	Weeks	Length of Labor	Baby's Weight	Sex	Type of Delivery	Anesthesia	Complications	Location
EXAMPLE:	01/15/75	40	12	6 lb. 2 oz.	F	Vaginal	Epidural	HBP. Gest. Diabetes.	HCGH

Social History

Occupation: _____

Are you? Married Single Engaged Significant other Divorced Widowed Same Sex Partner

Significant other's name: _____ Phone# _____

Other emergency contact name: _____ Phone # _____

Tobacco Use: Never Current ___ # of Cigarettes per day Former, Quit at age _____

Any alcohol use? YES NO *If yes, the average number of drinks per week _____

Do you use street drugs? YES NO *If yes, the type used and last use _____

How many times and how long per week do you exercise? (circle) 1X 2X 3X 4X 5X+

Per session: 20 mins. 30 mins 45 mins 60+ mins

Do you eat a healthy diet? Daily Some No

Any history of violence or abuse in your current household or in your past? _____NO_____YES

Do you have any cultural or religious considerations that need special attention? _____NO_____YES

*****Subject to the needs of your health, a scheduled appointment may be changed by the provider to a different type of appointment.** _____ (Please Initial)

Patient signature _____ Date: _____