Woman's Clinic, PA

Patient Name: _____ **Age:** _____ **Date of Birth:** _____

Appointment Time: _____ **Arrival Time:** _____ **Appt Reason:** _____ **Physician:** _____

Have you been to our clinic in the last 3 years? □Yes □No **Insurance Changes since last visit?** _____

Preferred Pharmacy: _____ **City:** _____

Has any of your medical information changed since your last visit here? □Yes □ No

STOP HERE, and return this form to the receptionist.

She will return it to you if you need to fill it out at the request of your physician.

Purpose of visit:

□ Well Woman
□ Problem
□ Follow Up
□ Post Op
□ Post Partum

Summary of any Current Problems:

Primary Care Doctor:

Any Changes in Current Medications: □Yes □ No

Drug Name:	Dosage:	Prescribed By:	Drug Name:	Dosage:	Prescribed By:

Allergies: _____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

Please Update the Following Information to keep your chart current:

Date of Last Menses	
How many days between periods?	
How long does your menses last?	
Flow?	Heavy Moderate Light
Do you have pain with menses?	Mild Moderate Severe
Do you have bleeding between periods?	
Do you have pelvic pain?	
How bad is your pain? Please rate 1-10 (10 highest)	
Location of pain?	
Alleviating factors?	
What makes pain better?	
Do you have vaginal discharge?	
Birth Control Method?	
Abnormal Vaginal Bleeding?	
Hot Flashes?	
Night Sweats?	
Decreased Sex Drive?	
Pain with Sex?	
Loss of control of urine?	
Urgency of urination?	
Frequent Urination?	
Incomplete Emptying of bladder?	
Urine Loss with Coughing, sneezing, jumping or lifting	

PAST MEDICAL HISTORY:

Any new medical problems or surgeries since your last visit with me:

Family History

Any Family Members with changes in medical conditions since your last visit with me?

Condition	Relationship	Condition	Relationship:
□ Diabetes	_____	□ Breast Cancer	_____
□ Stroke	_____	□ Colon Cancer	_____
□ Heart Attack	_____	□ Ovarian Cancer	_____
□ High Blood Pressure	_____	□ Other: (Describe):	_____

Social History

Marital Status: □ Single □Married □Widowed □Divorced □Separated □ Engaged

Personal Habits:

Have you ever smoked? □Yes □ No Are you currently smoking? □Yes □ No packs per day _____

Are you interested in quitting? □Yes □ No How long since you have stopped smoking (if you ever smoked)?_____

Alcohol Use: □Yes □ No Drinks per week?_____

Recreational Drug Use □Yes □ No Type:_____

Seat Belt Use □Yes □ No

Regular Exercise □Yes □ No Describe: _____

Review of Symptoms

Please mark all that apply to your visit TODAY

□Fatigue
□Weight Loss
□Weight Gain
□Loss of appetite
□Change in Height

□Blurry Vision

□Double Vision
□Headache
□Vertigo
□Lightheadedness
□Sore Throat
□Dental Problems

□Breast Lumps
□Breast Tenderness
□Breast Swelling
□Nipple Discharge

□Chest Pain
□Irregular Heart Beat
□Lower Extremity Swelling
□Fainting

□ Shortness of Breath
□Wheezing
□Cough

□Nausea
□Vomiting
□Constipation
□Blood in stool

□Heart Burn
□Involuntary loss of gas or stool

□Urgency to urinate
□Frequency of urination

□Painful Urination
□Blood in urine
□Incomplete Emptying of Bladder
□Difficulty with urination
□Urine Loss with coughing or sneezing

□Rash
□Moles (new growth or changes)

□Numbness
□Memory Difficulties
□Joint Pain
□Muscle Pain
□Muscle Weakness

□Heat Intolerance
□Cold Intolerance
□Hair Loss
□Hot Flashes
□Night Sweats

□Anxiety
□Frequent crying
□Depression
□Difficulty Sleeping

□Easy Bruising
□ Bleed Easily
□Enlarged Lymph Glands

We sincerely appreciate you filling out this form in its entirety. This ensures that you receive the highest quality of care possible.