_____NP EST PT_____

COMPREHENSIVE WOMEN'S HEALTHCARE

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Patient Name: Today's Date:

Birth Date: Age: Date of Last Period:

Primary Care Physician: Referred By:

SUBJECTIVE

1. Why are we seeing you today?

2. Are you having a problem would you like evaluated today? (circle) YES NO What?

YOUR MENSTRUAL HISTORY

Age at first menses: # of days they last:

# of days in between: # of heavy days:

How often do you change a tampon or pad on your heaviest days?

Age of Menopause:

PREGNANCY HISTORY

Have you ever been pregnant (circle one) YES NO

How many times: How many children:

Complications:

YOUR MEDICAL HISTORY	YES	NO	COMMENT
Abuse			
Abnormal PAP Smear			
Breast Problems			
Ovarian Cyst			
Chlamydia, Genital Warts, HPV, GC			
HIV, Syphilis (Circle which one)			
Uterine Fibroids			
Infertility			
Endometriosis			
Vaginal Infection or Pain			
Urinary Problems			
Sexual Problems			
Painful Periods			
Heavy Periods			
Premenstrual Syndrome			
Menopausal Symptoms/Problems			
Depression and/or Anxiety			
Cancer:			
Auto Immune Condition			
Diabetes			
High BP			
High Cholesterol			
Bone Loss			
Migraines/Nuerological Problems			
Stomach/Intestinal Issues			
Thyroid Problem			
Blood Clot or Stroke			
Other:			

YOUR FAMILY HISTORY	YES	NO	
Cancer:			
Blood Clots(in veins or lungs):			
Heart Disease			
Diabetes			
Stroke			
Osteoporosis			
Mental Illness			
Auto Immune Condition			
Other:			
LIST ALL SURGERIES Complications?	**YES**	**NO**	

CURRENT MEDICATIONS (include over the counter and vitamins)

DRUG ALLERGIES	REACTION

SOCIAL / SEXUAL HISTORY (circle one)

Do you have sex with: Men Women Both

What Method of birth control do you and/or your partner use:

Do you smoke marijuana or use drugs? YES NO

Do you have a living will? YES NO

Have you had an HPV vaccine? YES NO

Have you had a flu shot? YES NO

Have you had the Hepatitis B Vaccine? YES NO

Do you smoke cigarettes? YES NO

Do you drink alcohol? YES NO

OFFICE USE ONLY

Year 1st seen: Date of last WWE /WT

Today's BP HT WT

Date of last PAP: Result:

Date of last Mammo: Result:

Where:

Colonoscopy NL / Abnormal Date:

BMD NL / Ostropenia / Osteoporosis Date:

Pharm #