Westside
Physicians for Women

Patient Name_____ Date _____

How did you hear about us? (Check one):

□ Primary Care Physician □ Specialist Physician □ Family Member □ Friend □ Insurance Directory □ Internet

□ Yellow Pages □ other (please specify) _____

Name of □ Spouse □ Guardian □ Partner (choose one):_____

Reason for your visit today: _____

Personal History:

Do you have:	Yes	No	Do you have:	Yes	No
Asthma			Anemia		
Arthritis			History of blood clots		
Depression			Cancer		
Heart Disease			Seizures		
Kidney Disease			Personal history of breast disease / cancer		
History of Stroke			History of Rheumatic Fever		
Ulcers			Thyroid Disease		
Mitral Valve Prolapse			Diabetes		
High Cholesterol			History of Blood Disorder		
History of Blood Transfusion			History of Tuberculosis		
Gallbladder Disorder			High Blood Pressure		
Vision/Hearing/Speech Disorder			Liver Disorder		
			History of reaction to general anesthesia		

Other conditions: _____

Allergies to Medications:

1. _____ 2._____ 3._____ 4._____

5. _____ 6._____ 7._____ 8._____

Medications / Supplements / Vitamins (Please list with dosage): _____

_____

_____

_____

Menstrual History:

Date of last menstrual period _____
Age menses began _____
Age of menopause _____
Cycles typically occur every _____ days
Cycles typically last _____ days
Cycles are typically □ Light □ Moderate □ Heavy
Are your cycles painful □ Yes □ No
Are you sexually active □ Yes □ No

Preventative:

Have you had:	Yes	No	Date
Mammogram	□	□	_____
Pap smear	□	□	_____
Colonoscopy	□	□	_____
Bone Density Test	□	□	_____
Cholesterol Screen	□	□	_____
Thyroid Screen	□	□	_____
Sugar Screen	□	□	_____

Gynecologic History:

Have you ever had	Yes	No	Have you ever had	Yes	No
Abnormal Pap Smear			Chlamydia		
Gonorrhea			Genital warts / HPV / Condyloma		
Herpes			PID – Pelvic Inflammatory Disease		
Hepatitis			Syphilis		

Past Surgeries (if yes, please note approximate date and reason):

Surgery	Yes	No	Approximate Date and Reason
D & C			
Cryotherapy of cervix			
Cone / LEEP / Laser Cervix			
Hysterectomy			
Breast Biopsy			
Laparoscopy			
Appendectomy			
Tubal Ligation			

Other surgery not listed: _____

_____

Pregnancy History:

Year	Type of Delivery (c/section, vaginal delivery, miscarriage, etc.	Complications

Social History: **Yes** **No**

Do you use tobacco products? □ □ Packs per day _____
Do you drink? □ □ Rarely □ Socially □ Daily □
Do you use illegal drugs? □ □
Are you a past or present victim of abuse? □ □

Family History:

Do you have a family history of	Yes	No	Relation (please indicate Mother's or Father's side)
Breast Cancer			
Uterine / Ovarian Cancer			
Colon Cancer			
Blood clotting or clotting disorder			
Heart Disease			
Osteoporosis			
High Blood Pressure			
Stroke			
Diabetes			

Review of Systems:

Constitutional	Current	Past	Comments
Weight loss			
Weight gain			
Fever			
Fatigue			
Eyes			
Vision Changes			
ENT/Mouth			
Sinus problems			
Sore throat			
Cardiovascular			
Chest pain			
Swelling of legs			
Respiratory			
Shortness of breath			
Chronic cough			
Gastrointestinal			
Frequent diarrhea			
Blood in stool			
Nausea / vomiting			
Constipation			
Genitoruinary			
Blood in urine			
Pain with urination			
Urgency			
Frequent urination			
Leakage with cough or sneeze			
Skin / Breast			
Pain in breast			
Discharge			
Masses			
Rash or ulcer			
Neurological			
Seizures			
Psychiatric			
Depression			
Frequent crying			
Endocrine			
Dry skin			
Abnormal thirst			
Hot flashes			
Hematologic			
Frequent bruising			
Cuts that do not stop bleeding			