Advanced Menstrual Care Center

Control your period. Improve your life!

Name:_____ Appointment Date:_____

Birthdate: _____ Age:_____ Sex (please circle one): Female Transgender

This form is a part of your medical record. Please be accurate and complete. If changes or modifications are required, please inform any member of our staff so we may update your records. A page can be added for explanations.

Reason for this visit

Expectations & desired outcome

Current Medications, Supplements, and OTC Therapy **Check here if none** ☐

Name	Dose	How often	Reason

Medical History

List current and chronic health problems. **Check here if none** ☐

Problem/Concern	Active? ☑	Diagnosis Date	Treatment(s)

Allergies to Drugs, Medications, Nuts, Foods, or Latex **Check here if none** ☐

Allergy	Reaction	Comments

Gyn History

Age of first period? _____ Days between periods? _____ Length of flow? _____

Pads/Tampons per day? _____ Clots? Yes ☐ No ☐ Pain? Yes ☐ No ☐

First day of last period? _____Prior period? _____Are periods regular? Yes ☐ No ☐

Current Birth Control Method **Check all that apply.** **Check here if none** ☐

Condoms ☐ Pills ☐ IUD ☐ Depo Provera ☐ Nexplanon ☐ Diaphragm ☐ Foam ☐

Essure ☐ Vasectomy ☐ Tubal Ligation ☐ Other_____

Pap Smear History **Check here if none** ☐

Date of last pap? _____ Result?_____ HPV Positive ☐ HPV Negative ☐

Any abnormal pap smears? Yes ☐ No ☐ (If Yes, please indicate date)_____

Did you receive Gardasil HPV vaccine? Yes ☐ No ☐ Did you complete it? Yes ☐ No ☐

Name:_____ DOB:_____ Date:_____

Sexual History

Check here if none ☐

Are you currently sexually active? Yes ☐ No ☐ Number of partners in last 12 months?_____

Total sex partners _____ # of opposite sex partners _____ # of same sex partners _____

Sexually Transmitted Infection History? Yes ☐ No ☐ Please list (diagnosis, date, & treatment):

Screening Test History

Check here if none ☐

Test Performed	Date	Result	Comments
Mammogram			
Colonoscopy			
Bone density			
Other (describe)			

Pregnancy History

Check here if none ☐

Pregnancy	Number	Date	Comments
Full term vaginal deliveries			
Full term c-section deliveries			
Preterm vaginal deliveries			
Preterm C-section deliveries			
Miscarriages			
Abortions			
Ectopic pregnancy(s)			
Children living			
Adopted			

Surgery History

Check here if none ☐

Date	Type of Surgery	Hospital/ASC City & State	Result & Comments

Hospital & Psychiatric Admission History

Check here if none ☐

Date	Hospital	City & State	Reason for Admission

Name:_____ DOB:_____ Date:_____

Family History

Check ☑ the history that applies for each family member.

	Age	Ovarian Cancer	Breast Cancer	Colon Cancer	Diabetes	High Blood Pressure	Heart Disease	Stroke	Blood Clots	Comments
Mother										
Father										
Siblings										
Children										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										

Siblings (number): Brothers ____ Sisters _____

Children (number): Sons _____ Daughters _____

Social History

Activity	Comments
Birthplace?	
Education?	
Employment?	
Military?	
Incarceration?	
International Travel: Where, When?	
Home: Rent, Own?	
Household Residents:	
Pets?	

Activity	✓	Type, Amount & Frequency	Comments
Drink alcohol?			
Use tobacco?			
Use street drugs?			
Exercise?			
Diet?			
Family activities?			
Hobbies?			
Religious/Spiritual?			
Volunteer?			

Other concerns you wish addressed at this consultation:

How did you learn about this practice?

How may we improve our service to you?

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Date:_____

Name:_____ Birthdate:_____

Review of Systems

The review of systems is a routine part of any complete medical history. It is confidential and becomes an important part of your medical record. This questionnaire searches for subtle signs of problems that may require further evaluation. Please note that a healthy person will have many of these symptoms intermittently. Those symptoms that are persistent, recurrent, or severe are the most important in a patient's history. Please circle all symptoms that apply to you, or check the box, "No Concerns", if none of the symptoms apply.

Body System	Symptoms (Please Circle All That Apply)	No Concerns ☑	Comments
General Health	Excessive fatigue | Unexplained weight loss | Excess weight gain | Loss of appetite | Fever | Night sweats | Insomnia		
Heart & Vessels	Palpitations | Irregular heartbeat | Racing heart | Chest pain | Persistent swelling of legs | Pain in legs when walking | Sleeping on 2 or more pillows | Frequent dizziness | Cold hands or feet		
Lungs & Airways	Shortness of breath | Wheezing | Difficulty catching breath | Frequent, chronic coughing | Coughing up blood | Coughing up sputum | Pain on breathing | Prior TB | TB exposure | Oxygen therapy | Abnormal X-rays		
Ears, Nose, Throat	Difficulty hearing | Ear pain | Ear discharge | Chronic runny nose | Post-nasal drip | Chronic nasal congestion | Sinus pain | Ringing in ears | Nosebleeds | Sore throat | Hoarseness | Facial pain or numbness | Eye pain | Tunnel vision | Floaters | Bleeding gums | Dental problems | Dentures | Partial plates | Contacts | Other implants of any type		
Intestinal Tract	Heartburn | Constipation | Frequent diarrhea | Black stools | Bloody stools | Frequent vomiting | Bloody vomit | Abdominal pain | Leaking stools | Painful bowel movements | Change in bowel movements | Jaundice | Loss of appetite | Loss of taste		
Kidneys & Bladder	Painful urination | Leaking urine | Bloody urine | Prior kidney or bladder infections | Painful urination | Urinary frequency | Urgency of urine | Discolored urine		
Muscle & Bones	Joint pain | Joint swelling | Difficulty moving joints | Aching muscles | Knots on skin, joints or muscles		
Skin, Hair & Breasts	Persistent rash | Chronic itching | Changing moles | Chronic ulcers | Draining ulcers | Poor wound healing | Hair loss | Excessive hairiness |		
Brain & Nerves	Frequent headaches | Blurred vision | Double vision | Loss of vision | Difficulty walking | Difficulty with balance | Falling | Dizziness | Tremor | Numbness or loss of sensation | Weakness of a body part or area |		
Glands	Intolerance to heat or cold | Excess hunger | Excess thirst | Menstrual irregularities		
Blood & Lymph	Easy bruising or bleeding | Difficulty stopping bleeding | Anemia | Swollen lymph glands | Prior blood clots to lungs or other areas		
Immune System	Seasonal allergies | Frequent infections | History of or risk for HIV | Severe allergic reactions		
Psychiatric	Current or prior depression | Prior psychiatric diagnosis or treatment | Suicidal thoughts | Homicidal thoughts |Mood swings | Compulsions | Anxiety | Obsessive thoughts | Hallucinations | Memory loss		
Women's Health	Painful sex | Painful periods | Menstrual clots | Missing periods | Heavy periods | Infertility | Breast pain | Breast lump | Breast discharge		

Comments:_____

_____

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