Plano Wellness

Form must be filled out completely. Please check ☐ (Box) labeled "None" or "No" if it does not apply.

Patient Health History

Name: _____ **DOB:** _____ **Age:** _____

E-mail:

(E-mail address needed to access Web Portal) **Phone #**: _____

Address: _____

Local Pharmacy: _____ **Pharmacy Phone # *or* Address:** _____

Mail Order Pharmacy: _____ Compounding Pharmacy: _____

Insurance Main Card Holder? ☐ Self ☐ Spouse ☐ Parent

Spouse or Parent Name _____ **DOB:** _____

I give permission to Plano Wellness personnel to give any and all medical information pertaining to myself, including appointment reminders, **to the individual other than myself:**

Name: _____ **Phone #** _____ **Relationship** _____

Reason for today's visit *(check all that apply)*

☐ Annual ☐ BioTE® ☐ Hormone Problems ☐ Abnormal Pap ☐ Abnormal Bleeding
☐ Abnormal Imaging ☐ Birth Control ☐Surgery ☐ Second opinion ☐ Other_____

Health Screening

Tobacco: ☐ Never Current: ☐ Sporadic ☐ Daily ☐Former, Quit ____/____/_____

Have you completed the 3-part HPV/Gardasil vaccine? ☐No ☐Yes ***If yes, when?*** ____/____/_____

Is your Tetanus vaccine current? ☐No ☐Yes ***If yes, when?*** ____/____/_____ ***Do you want one today?*** ☐No ☐Yes

Alcohol: ☐ Never Current: ☐ Sporadic ☐ Daily ☐Former, Quit ____/____/_____

Exercise: ☐ Never Current: ☐ Sporadic ☐ 3-4x/wk ☐ Daily

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Remarried

Primary Care Physician: _____

OFFICE USE ONLY	Ht:	Wt:	BP:	P:	Temp:	UA:

Approximate date of last:	
Pap Smear	
Mammogram	
Colonoscopy	
Bone Density	

Medication Allergy: ☐ None	Reaction:

Current Medication: ☐ None	Strength:	Taken how often:

GYN History

First day of Last Menstrual Cycle: ____/____/_____
Period started: Age _____ Date: ____/____/_____ **Menopause:** Age _____ Date: ____/____/_____
Not having periods: ☐Nursing ☐Birth Control ☐Menopause ☐Endometrial Ablation ☐Hysterectomy ☐Unknown
Menstrual Timing: ☐Regular Cycle ☐Irregular Cycle every: ____days ____weeks ____months
Menstrual Length: ____days Flow: ____Heavy days ____Moderate days ____Light days
Cramps: ☐No ☐Yes Clots: ☐No ☐Yes
Are you sexually active? ☐No ☐Yes **Is your intimate life satisfactory?** ☐No ☐Yes
Hx of physical, emotional or sexual abuse? ☐No ☐Yes **Sexual Preference:** ☐Male ☐Female
Are you trying to conceive? ☐No ☐Yes ***If yes, for how long?*** _____

Method of birth control you are using?

- ☐ *Not sexually active yet*
- ☐ *None, would welcome pregnancy*
- ☐ *None, History of Infertility*
- ☐ Abstinence
- ☐ Birth Control Pill
- ☐ Condoms
- ☐ Depo Provera
- ☐ Diaphragm
- ☐ Essure
- ☐ IUD 3 yr Progestin
- ☐ IUD 5 yr Progestin
- ☐ IUD 10 yr Copper
- ☐ Natural Family Planning
- ☐ Hysterectomy
- ☐ Patch
- ☐ Vaginal Ring
- ☐ Progestin Implant
- ☐ Rhythm
- ☐ Salpingectomies, Bilateral
- ☐ Same sex partner
- ☐ Tubal Ligation, Bilateral
- ☐ Vaginal hormone inset
- ☐ Vaginal spermicide
- ☐ Vasectomy
- ☐Withdrawal

Past GYN History - **Do you have or have you ever had:** ☐ **None**

- ☐ Abnormal Pap Smear
- ☐ Amenorrhea (No periods)
- ☐ Anovulation
- ☐ Bartholin's gland cyst
- ☐ Cervical cancer
- ☐ Candidiasis (chronic yeast)
- ☐ Chlamydia
- ☐ Condyloma (genital warts)
- ☐ Cryotherapy
- ☐ Cystocele (dropped bladder)
- ☐ DES exposure in utero
- ☐ Dysplasia (pre-cancer)
- ☐ Dyspareunia (painful sex)
- ☐ Endometriosis
- ☐ Fibroid uterus
- ☐ Gonorrhea
- ☐ Heavy periods
- ☐ Herpes, genital
- ☐ HPV
- ☐ Hydrosalpinx
- ☐ Incontinence
- ☐ Infertility
- ☐ Irregular menses
- ☐ LEEP
- ☐ Ovarian cancer
- ☐ Ovarian problems
- ☐ Pelvic adhesions
- ☐ PID
- ☐ PMS
- ☐ Polycystic Ovaries (PCOS)
- ☐ Syphilis
- ☐ Trichomonas
- ☐ Uterine cancer
- ☐ Uterine Polyps
- ☐ Uterine Prolapse
- ☐ Vaginal or Vulvar Cancer

Past Obstetrical History ☐ **No Pregnancy History**

Total # of pregnancies	# of full-term deliveries	# of pre-term deliveries	# of miscarriages	# of terminations	# of ectopic
# of vaginal births	# of cesarean births	Largest birth weight	# of multiple births	# of stillbirths	

Pregnancy Complications ☐ **None**

- ☐ Breech
- ☐ Gestational Diabetes
- ☐ Hemorrhage
- ☐ Hypertension
- ☐ Incompetent cervix
- ☐ Postpartum depression
- ☐ Progesterone 1st Trimester
- ☐ Placenta previa
- ☐ Pre-term Labor
- ☐ Shoulder Dystocia
- ☐ Other _____
_____

YOUR Medical History ☐ None

- ☐ AIDS
- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood clotting disorder
- ☐ Breast cancer
- ☐ Cardiac arrhythmia
- ☐ Cholesterol(Hypercholesterolemia)
- ☐ Colon cancer
- ☐ Congestive heart disease
- ☐ COPD (Lung disease)
- ☐ Coronary heart disease
- ☐ Depression
- ☐ Diabetes
- ☐ DVT (venous embolism)
- ☐ Epilepsy
- ☐ Esophageal reflux
- ☐ Fibromyalgia
- ☐ Genetic disorder
- ☐ Hepatitis (**A**, **B**, or **C**)
- ☐ Hernia
- ☐ HIV
- ☐ Hypertension (HTN)
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Kidney stone
- ☐ Lung cancer
- ☐ Migraine headaches
- ☐ Mitral valve prolapse (MVP)
- ☐ Myocardial infarction
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Skin cancer
- ☐ Stroke (CVA)
- ☐ Suicide
- ☐ Thyroid (**Hypo** or **Hyper**)
- ☐ Transient Ischemic attack
- ☐ Triglycerides, Elevated
- ☐ Ulcer
- ☐ Other:_____
  _____
  _____
  _____

YOUR Past Surgical History ☐ None

- ☐ Abdominal, exploratory
- ☐ Appendectomy
- ☐ Back surgery
- ☐ Bariatric surgery
- ☐ Breast augmentation
- ☐ Breast Lumpectomy
- ☐ Bladder lift
- ☐ Cesarean section
- ☐ CABG (coronary bypass)
- ☐ Cervix procedure
- ☐ Cholecystectomy (gallbladder)
- ☐ Colon Resection
- ☐ D&C
- ☐ Endometrial Ablation
- ☐ Fallopian tube surgery
- ☐ Fibroid surgery
- ☐ Hemorrhoid
- ☐ Hernia
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Knee surgery
- ☐ Laparoscopy
- ☐ Ovarian surgery
- ☐ Pacemaker implant
- ☐ Plastic surgery
- ☐ Splenectomy
- ☐ Thyroidectomy
- ☐ Other _____
  _____
  _____

Have you ever been hospitalized? ☐No ☐Yes

Family History Questionnaire for Common Hereditary Cancer syndromes

Has any *family member* ever had genetic testing for Hereditary Risk of Cancer? ☐No ☐Yes

If yes, please explain: _____

_____

Family History ☐None

(Provide Age of diagnosis)	**Mother**	**Father**	**Grand Parent**		**Sibling(s)**		**Aunt**	**Uncle**
			GM	**GF**	**Sister**	**Brother**		
Breast Cancer								
Ovarian Cancer								
Pancreatic Cancer								
Uterine Cancer								
Prostate Cancer								
Colon Cancer (>10 polyps)								
Melanoma								
Other Cancer								

Check family members with the following conditions: ☐ None

(Provide Age of diagnosis)		Mother	Father	Grand-Mother	Grand-Father	Sister	Brother	Aunt	Uncle
Alzheimer's Disease	Alz								
Blood Clots	Clo								
High Cholesterol/triglycerides	Dis								
Coronary Heart Disease	CAD								
Diabetes	DM								
Genetic Disorder	Gen								
Hepatitis (A, B, or C)	Hep								
Hypertension	HTN								
Myocardial Infarction	MI								
Osteoporosis	Ost								
Stroke	CVA								
Thyroid Disorder	Thy								

Review of Systems: *(Please circle any you **currently** have):* ☐None

General	Chills Fatigue Fever Night sweats Weight gain Weight loss
Eyes	Blind spots Floaters in the visual field Eye pain
Ears, Nose, Throat, Neck	Bleeding gums Hoarseness Swollen neck Decreased hearing Difficulty swallowing Nosebleed
Endocrine	Cold intolerance Heat intolerance Hair loss Hot flashes Excessive hair growth Thirst Breast discharge
Respiratory	Hemoptysis (bloody cough) Shortness of breath Wheezing
Cardiac	Faint Chest pain Palpitations Shortness of breath at rest
GI	Abdominal pain Blood in stool Constipation Diarrhea Nausea Vomiting
Heme/Lymph	Anemia Easy bruising Prolonged bleeding Swollen glands
GU	Nocturia (urination at night) Pelvic pain Vaginal dryness Vaginal discharge Vaginal itching Vaginal burning Low sex drive Difficult to climax Painful intercourse Blood after intercourse Blood in urine Frequent urination Painful urination
Musculoskeletal	Back problems (pain) Painful joints Weakness Swollen joints
Skin	Acne Dry skin New mole Rash
Neurologic	Dizziness Headache Poor memory Tingling/Numbness
Psychiatric	Irritability Anxiety Depressed mood Difficulty sleeping Suicidal thoughts Insomnia