advanced womens health specialists

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Name:_____ Date of Birth:_____ Today's Date:_____

Medical History (any new from last visit):

- ☐Asthma
- ☐Arthritis
- ☐ Heart Murmur
- ☐ Heart Disease
- ☐Stroke
- ☐Epilepsy
- ☐Migraines
- ☐Lupus
- ☐Emphysema
- ☐ Depression/Mental Illness
- ☐High Blood Pressure
- ☐HIV
- ☐Kidney Disease
- ☐Osteoporosis
- ☐Cholesterol
- ☐Thyroid Disease: Hyperthyroid
- ☐Thyroid Disease: Hypothyroid
- ☐Ovarian Cysts
- ☐Diabetes: Type I
- ☐Diabetes: Type II
- ☐Polycycstic Ovaries (PCOS)
- ☐Endometriosis
- ☐Uterine Fibroids
- ☐Cancer (Please specify type)
- ☐_____
- ☐Other:
- ☐_____

Social History: (please circle): Single Married Divorced Widowed Female Partner Male Partner

Occupation:_____ Student: Yes No

Do you use tobacco? Yes No Previously How many packs/cigarettes per day?_____
Do you use alcohol? Yes No Previously How many drinks per day/week?_____
Do you use drugs? Yes No Previously What kind?_____ How Often?_____

OB/GYN History:

First Day of your last period:_____
Age of first period:____ How long do your periods last?_____ How many days between periods?_____
Cramping during periods? Yes No Flow: Heavy Medium Light Clots? Yes No
Are you sexually active? Yes No Never
Current sexual partner(s)? Male Female Both
Do you have a history of sexually transmitted diseases? Yes No Please specify type:_____
What do you use for contraception?_____
What have you previously used? IUD Pills Condoms Patch NuvaRing Other:_____
Date of last pap smear:_____ Normal Abnormal Date of last mammogram:_____ Normal Abnormal
Date of last colonoscopy:_____ Normal Abnormal Date of last bone density:_____ Normal Abnormal
How many times have you been pregnant?_____ Number of children:_____

Date of Delivery	Weeks at Delivery	C-Section/Vaginal	Male/Female	Baby's birth weight	Complications

Name: _____

Surgical History (any new from last visit):

Date	Type of surgery	Date	Type of surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication (please include vitamins and over the counter medications):

Medication	Dosage (mg, IU)	How often do you take it
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies (please include medications, environmental, and food allergies):

Allergy	Reaction	Allergy	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

Family Medical History (please include relationship to you – parents, siblings, grandparents):

☐ Diabetes: **Type I** _____	☐ Osteoporosis _____	☐ Ovarian Cancer _____
☐ Diabetes: **Type II** _____	☐ Stroke _____	☐ Other Cancer (please specify)
☐ High Blood Pressure _____	☐ Lupus _____	_____
☐ Depression/Mental Illness _____	☐ Heart Disease _____	_____
☐ Thyroid Disease: **Hypothyroid** _____	☐ Emphysema _____	☐ Other (please specify)
☐ Thyroid Disease: **Hyperthyroid** _____	☐ Breast Cancer _____	_____
☐ Kidney Disease _____	☐ Colon Cancer _____	_____

Review of Symptoms (please include any symptoms or problems you are experiencing today):

Concerns of problems you would like to discuss today: _____

☐ Tired/Fatigue	☐ Joint Pain	☐ Incontinence
☐ Loss of Appetite	☐ Loss of Hair	☐ Anxiety
☐ Bleeding of Gums	☐ Memory/Concentration Difficulty	☐ Difficulty Sleeping
☐ Headache	☐ Decreased Libido (sex drive)	☐ Weight Loss
☐ Chest Pain	☐ Ringing in Ears	☐ Weight Gain
☐ Shortness of Breath	☐ Vomiting	☐ Lightheadedness
☐ Shortness of Breath with Exercise	☐ Blood in Stool	☐ Breast Lump
☐ Nausea	☐ Intolerance to Cold	☐ Breast Tenderness
☐ Frequent Urination at Night	☐ Intolerance to heat	☐ Nipple Discharge
☐ Urinary Frequency	☐ Night Sweats	☐ Constipation
☐ Urinary Urgency	☐ Decreased Hearing	☐ Hemorrhoids
☐ Blood in Urine	☐ Diarrhea	☐ Heartburn