Park NP Clinic
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WOMEN'S HEALTH INTAKE FORM

*Instructions: This is a multi-page fillable PDF form. Please fill out all pages in Acrobat Reader, Microsoft Edge or Google Chrome, and save the PDF with your name in the filename. Example: "**W_Intake_JaneDoe.pdf**." Email the completed form to julie@parknpclinic.com.*

Today's date:	

PATIENT DEMOGRAPHICS

Name:		Current Height:	
Date of Birth:		Current Weight:	
Primary Care Provider:		Last Visit:	
Other Specialists:			

What is the reason for your visit today?

REPRODUCTIVE INFORMATION

When was the first day of your most recent menstrual period?

Have you ever been sexually active? ◯ Yes ◯ No Are you currently sexually active? ◯ Yes ◯ No

How do you personally prevent pregnancy?
If you are taking oral contraceptives, we will need to discuss alternatives if you wish to take semaglutide or tirzepatide.

Do you desire pregnancy? ◯ Yes ◯ No Have you completed your family? ◯ Yes ◯ No

MEDICAL HISTORY

How are your periods? Check all that apply.

◯ Painful ◯ Moderate flow ◯ Absent ◯ Frequent
◯ Light flow ◯ Heavy flow ◯ Irregular ◯ Infrequent

Have you ever been diagnosed with a sexually transmitted disease? ◯ Yes ◯ No If yes, please list:

◯ HPV ◯ Chlamydia ◯ Trich ◯ Genital Warts
◯ Herpes ◯ Syphilis ◯ Gonorrhea ◯ HIV

Do you have a history of any of the following? Check all that apply.

◯ Addiction ◯ Alcohol intake ◯ Smoking (current) ◯ Smoking (past)
◯ Disordered eating ◯ Mental health concerns — If any, please explain below.

Do you have a history of any of the following? Check all that apply.

- ◯ Breast cancer
- ◯ Seizures/epilepsy
- ◯ Endometriosis
- ◯ Fibrocystic breast disease
- ◯ Polycystic ovarian syndrome
- ◯ Endometrial polyps
- ◯ Uterine fibroids
- ◯ Hashimoto's thyroiditis
- ◯ Anemia
- ◯ Liver disease
- ◯ Depression/anxiety
- ◯ DVT/pulmonary embolus
- ◯ Migraines
- ◯ Pancreatitis
- ◯ High cholesterol
- ◯ Heart disease
- ◯ Kidney disease
- ◯ Stroke
- ◯ Sleep apnea
- ◯ Hypertension
- ◯ Gallbladder disease
- ◯ GI problems — Please describe: _____
- ◯ Thyroid problems — Please describe: _____
- ◯ Other — Please describe: _____

SURGICAL HISTORY

Please list:

FAMILY MEDICAL HISTORY

Please check all that apply:

- ◯ Dementia
- ◯ Addiction
- ◯ Depression/anxiety
- ◯ Diabetes
- ◯ Medullary thyroid cancer
- ◯ Heart disease
- ◯ High cholesterol
- ◯ Pancreatic cancer
- ◯ Osteoporosis
- ◯ Stroke
- ◯ Heart attack
- ◯ Breast cancer
- ◯ Ovarian cancer
- ◯ Endometrial/uterine cancer
- ◯ Colorectal cancer
- ◯ Blood clot/DVT/PE
- ◯ Multiple endocrine neoplasia syndrome type 2 (MEN 2)

TESTING

Date of last colorectal cancer screening and result:

Cologuard		
Colonoscopy		

When were you instructed to follow up?

Date of last mammogram and result:

Do you have a history of abnormal mammograms? ◯ Yes ◯ No If yes, please explain:

Do you have a history of procedures on the breast? ◯ Yes ◯ No If yes, please explain:

Date of last bone density scan and result:

Date of last pap and result:

Have you ever had a procedure performed on your cervix? ◯ Yes ◯ No If yes, please explain:

SYMPTOMS

Please indicate any symptoms you are experiencing and their severity:

Symptom	None	Mild	Moderate	Severe	Very severe
Physical exhaustion (fatigue, energy, stamina, motivation)	○	○	○	○	○
Sleep problems (difficulty falling asleep or sleeping through the night)	○	○	○	○	○
Irritability (mood swings, feeling aggressive, angers easily)	○	○	○	○	○
Anxiety (feeling overwhelmed, panicky or nervous)	○	○	○	○	○
Decline in drive or interest (loss of "zest" for life, feeling sad or down)	○	○	○	○	○
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	○	○	○	○	○
Difficulties with memory (concentration, finding the right word, retaining information)	○	○	○	○	○
Vaginal dryness or difficulty with sexual intercourse	○	○	○	○	○
Sexual problems (change in desire, activity, orgasm and/or satisfaction)	○	○	○	○	○
Sweating (night sweats or increase episodes of sweating)	○	○	○	○	○
Hot flashes (bursts that start in the chest and last for a short duration)	○	○	○	○	○
Hair loss, thinning or change in texture of hair	○	○	○	○	○
Feeling cold all the time, having cold hands and feet	○	○	○	○	○
Headaches or migraines (increase in frequency or intensity)	○	○	○	○	○
Weight (difficulty losing weight despite diet and exercise)	○	○	○	○	○
Bladder problems (difficulty urinating, increase need to urinate, incontinence)	○	○	○	○	○

Have you ever taken hormone replacement therapy? ○ Yes ○ No If yes, please explain:

WEIGHT LOSS

What are your current hobbies?

What do you think your current obstacles are to maintaining a healthy weight?

Are you in good health at the present time to the best of your knowledge? ◯ Yes ◯ No

Do you have any digestive issues currently? ◯ Yes ◯ No

If yes, what symptoms do you experience regularly?

How do you manage those symptoms?

How many hours do you sleep at night? Is your sleep interrupted? ◯ Yes ◯ No

Do you wake up feeling rested? ◯ Yes ◯ No

Have you been evaluated for sleep apnea? ◯ Yes ◯ No

What do you consider your ideal weight? lbs How much weight do you want to lose? lbs

Do you engage in any type of regular exercise? ◯ Yes ◯ No If yes, what is your routine?

Do you have any issues that limit your ability to exercise? ◯ Yes ◯ No If yes, please describe:

Have you ever taken weight loss medication? ◯ Yes ◯ No If yes, what have you taken?

What is your vision of your best self?