

CENTRAL PHOENIX WOMEN'S HEALTH CARE

NAME: _____ Age: _____ Height: _____ Weight: _____

Date: _____ Reason For Visit Today: _____

PAST MEDICAL HISTORY

<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> HIV	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Arthritis/ Joint Pain	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney Infections	<input type="checkbox"/> Yellow jaundice
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Other List Below
<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures/convulsions/epilepsy	
<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tuberculosis	

GYNECOLOGY HISTORY

☐ Chlamydia ☐ Gonorrhea ☐ Genital Warts ☐ Herpes ☐ Syphilis ☐ Vaginosis ☐ Trichomonas

What is the date of your last pap smear? _____

Have you ever had an abnormal Pap smear test? Yes ☐ No ☐ If yes when: _____

Do you consider yourself: ☐ Straight/Heterosexual ☐ Bisexual ☐ Lesbian, gay or homosexual
☐ Something else (please specify): _____

Current Gender Identity: ☐ Female ☐ Male ☐ Transgender ☐ Add'l category (please specify): _____

IMMUNIZATIONS

Tetanus	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____	HPV	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
Flu Shot	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____				

PAST SURGERIES

Past Surgery	Date	Past Surgery	Date

CURRENT MEDICATIONS / HERBS / VITAMINS / NUTRITIONAL SUPPLEMENTS

DRUG NAME	DOSAGE	DRUG NAME	DOSAGE

MEDICATION ALLERGIES / FOOD ALLERGIES

Drug Allergies	Reaction	Drug Allergies	Reaction

Are you allergic to Peanuts? Yes ☐ No ☐ Are you allergic to eggs? Yes ☐ No ☐

FAMILY MEDICAL HISTORY

Condition:	Yes	Relative / Age	Mother's Side	Father's Side
Alcoholism	<input type="checkbox"/>			
Breast Cancer	<input type="checkbox"/>			
Colon Cancer	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>			
High Blood Pressure	<input type="checkbox"/>			
Heart disease	<input type="checkbox"/>			
Ovarian Cancer	<input type="checkbox"/>			
Stroke	<input type="checkbox"/>			
Other:				

REPRODUCTIVE HISTORY

Age at First Menstrual Period _____ Period Frequency _____ Duration of Flow _____ (days)
 Date of Last Menstrual Period (LMP) _____ Flow: Light Normal Heavy
 Current Birth Control Method _____ Age at Menopause (if applicable) _____
 Do you have sex with ☐ Men ☐ Women ☐ Both ☐ Virgin ☐ Not sexually active
Obstetrical History: #No. of Pregnancies _____ Miscarriages _____ Abortions _____ Living Children _____

Delivery Date	Weeks	Birth weight	Sex	Delivery Type	Complications

SOCIAL HISTORY

Smoking	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Packs per Day _____	Years _____	Age when quit _____
Alcohol	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Drinks per Day _____	Drinks per Week _____	
Drug Use	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Regular Exercise	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seat Belt Use Yes <input type="checkbox"/> No <input type="checkbox"/>

PERSONAL SAFETY

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Has anyone close to you ever threatened to hurt you?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Has anyone ever hit, kicked, choked, or hurt you physically?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Has anyone, including your partner, ever forced you to have sex?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you ever afraid of your partner?

PLEASE CHECK (X) IF ANY OF THE FOLLOWING SYMPTOMS APPLY TO YOU CURRENTLY

CONSTITUTIONAL <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue EYES <input type="checkbox"/> Double vision <input type="checkbox"/> Spots before eyes <input type="checkbox"/> Vision changes EARS, NOSE, THROAT <input type="checkbox"/> Ear aches <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Sore throat <input type="checkbox"/> Mouth sores <input type="checkbox"/> Dental problems BREASTS <input type="checkbox"/> Pain in breast <input type="checkbox"/> Discharge <input type="checkbox"/> Masses	CARDIOVASCULAR <input type="checkbox"/> Painful breathing <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficult breathing on exertion <input type="checkbox"/> Swelling of legs <input type="checkbox"/> Palpitations of heart RESPIRATORY <input type="checkbox"/> Wheezing <input type="checkbox"/> Spitting up blood <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough, chronic GASTROINTESTINAL <input type="checkbox"/> Frequent diarrhea <input type="checkbox"/> Bloody stool <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Constipation GENITOURINARY <input type="checkbox"/> Blood in urine <input type="checkbox"/> Pain with urination <input type="checkbox"/> Urgency <input type="checkbox"/> Frequency of urination <input type="checkbox"/> Incomplete emptying <input type="checkbox"/> Stress incontinence <input type="checkbox"/> Abnormal periods <input type="checkbox"/> Painful intercourse	SKIN <input type="checkbox"/> Rash <input type="checkbox"/> Ulcers NEUROLOGIC <input type="checkbox"/> Dizziness <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness <input type="checkbox"/> Trouble walking MUSCULOSKELETAL <input type="checkbox"/> Muscle weakness ENDOCRINE <input type="checkbox"/> Dry skin <input type="checkbox"/> Abnormal thirst <input type="checkbox"/> Hot flashes PSYCHIATRIC <input type="checkbox"/> Depression <input type="checkbox"/> Frequent crying HEMATOLOGIC/LYMPHATIC <input type="checkbox"/> Easy bruising <input type="checkbox"/> Enlarged lymph nodes <input type="checkbox"/> Easy bleeding
---	---	---

Patient Signature _____ Date _____

Date Reviewed: ____/____/____

Date Reviewed: ____/____/____

Date Reviewed: ____/____/____

Patient Signature: _____

Patient Signature: _____

Patient Signature: _____

MD initials _____

MD initials _____

MD initials _____