**Associates in Women's Health, PC**
2801 Youngfield St., Suite 200 Golden, CO 80401
Phone: 303-940-1867 Fax: 303-940-1894

NAME_____ DOB_____

Do you have, or have you ever had in the past, any of the following medical problems:

____ diabetes
_____dense breast tissue
____ asthma or other breathing problems
____ thyroid problems
____ seizure disorders or migraines
____ cancer
____ other_____
____ high blood pressure
_____multiple breast biopsies
____ heart disease
____ blood clots
____ frequent urinary tract infections
____ liver problems (ie, hepatitis)

Have you had surgery in the past? If yes, please list
_____

_____

Do you take ANY medications regularly? If yes, please list.
_____

_____

Do you have any allergies to any medication? If yes, please list.
_____

_____

How many times have you been pregnant? ____ How many births? ____

Do you smoke? ____ If yes, how many packs per day? ____
Do you drink? ____ If yes, how much per day? ____
Have you ever used I.V. drugs? ____

Do you have a ***family history*** of any of the following (***please include relation, age of diagnosis and number of cases)***? Please review extended family on both sides as well.

_____breast cancer (male or female)
_____ovarian cancer
_____diabetes
_____colon cancer
_____colorectal polyps
_____heart disease
_____high blood pressure
_____endometrial cancer
_____pancreatic cancer
_____skin cancer (melanoma)
_____Ashkenazi Jewish heritage
_____prostate cancer
_____known genetic mutations
_____any other cancers

When did you last have:

Pap smear _____ Mammogram _____

Cholesterol level checked _____ Colonoscopy_____

Who is your primary care physician? _____

Do you still have a period? _____ If yes, are they:

_____ closer together than every 21 days
_____ irregular
_____ considerably heavier than before
_____ further apart than every two months

What are you currently using for birth control?_____

Any problems?_____

Do you consider yourself to be:____ heterosexual or straight____ gay or lesbian____bisexual

Have you ever had an abnormal Pap smear? _____ If yes, when?_____

How was it treated?_____

Do you currently have any of the problems:

_____ hot flashes
_____ vaginal dryness
_____ depression
_____ vaginal burning or frequent vaginal infections
_____ osteoporosis
_____ difficulty sleeping
_____ loss of bladder control
_____ irritability or unusual moodiness
____ frequent bladder infections
_____ painful intercourse
_____ memory loss

Have you ever taken estrogen? _____ Are you on it now? _____

Any problems with estrogen?

_____ breast tenderness
_____ weight gain
_____ headaches
_____ bloating
_____ irregular bleeding
_____ other _____

Are you currently using a calcium supplement? _____

If yes, how many mg/day? _____

Any other medical history information:

_____

_____