Associates in Women's Health, PC
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NAME_____ DOB_____

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

____diabetes
____asthma or other breathing problems
____dense breast tissue
____thyroid problems
____seizure disorders or migraines
____cancer
____other_____
____high blood pressure
____heart disease
____multiple breast biopsies
____blood clots
____frequent urinary tract infections
____liver problems (i.e. 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 _____

Who is your primary care physician? _____

How old were you when you when you started having periods?_____

How often do you have your periods:

____less than every 21 days____every 22-33 days ____greater than 34 days

How long does your period last?_____
Are they painful? _____
If so, what do you take for the pain? _____
Is it working adequately? _____
Do you experience any bleeding between cycles? _____

What are you currently using for birth control?_____
Are you experiencing any problems with it: _____
_____

Are you having any problems with sex?
____pain with intercourse ____decreased sex drive
____difficulty with lubrication

Do you leak urine? ____with coughing or sneezing ____spontaneously

Have you ever had an abnormal Pap smear? ____ If yes, when?____
How was it treated?_____

Have you ever had any of the following?
____gonorrhea ____chlamydia ____herpes ____HPV (warts)
____syphilis ____PID ____trichimonas

Are you currently using condoms if not in a mutually monogamous relationship? ____

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

Are you currently pregnant or have reason to believe you could be pregnant? ____
Have you ever had:
____abortion ____miscarriage
____preterm labor ____C-Section
____baby with a birth defect ____stillborn infant
____hemorrhage following the birth of a baby

Have you been trying to get pregnant for more than 12 months without success? ____