

PATIENT INFORMATION

MARITAL STATUS: S M D W

NAME: _____

LAST

FIRST

MIDDLE

EMAIL ADDRESS: _____ DRIVER'S LICENSE: _____

SOCIAL SECURITY: _____ - _____ - _____ DATE OF BIRTH: _____ - _____ - _____ AGE: _____

HOME ADDRESS: _____

STREET

CITY

STATE

ZIP CODE

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMPLOYER: _____ HOW LONG? YRS: _____ MOS: _____ OCCUPATION: _____

WORK ADDRESS: _____

STREET

CITY

STATE

ZIP CODE

SPOUSE'S NAME: _____ CELL PHONE: _____ WORK PHONE: _____

SPOUSE'S EMPLOYER: (NAME & ADDRESS): _____

INSURANCE

PRIMARY: SUBSCRIBER'S NAME: _____ POLICY # _____ SS#: _____ / _____ / _____

INSURANCE NAME: _____ PHONE: _____

BILLING ADDRESS: _____

STREET

CITY

STATE

ZIP CODE

SECONDARY: SUBSCRIBER'S NAME: _____ POLICY # _____ SS#: _____ / _____ / _____

INSURANCE NAME: _____ PHONE: _____

BILLING ADDRESS: _____

STREET

CITY

STATE

ZIP CODE

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

ADDRESS: _____

AUTHORIZATION: I authorize Women Care Providers (WCP) to furnish information to insurance carriers concerning my visit, and I hereby irrevocably assign to WCP all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

SIGNATURE: _____ DATE: _____

REFERRED TO US BY: _____ RELATIONSHIP: _____

PATIENT HISTORY

TODAY'S DATE: ___/___/___

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse

PAST MEDICAL HISTORY

MAJOR ILLNESS	YES (DATE)	NO	NOT SURE	MAJOR ILLNESS	YES (DATE)	NO	NOT SURE
AIDS				HEADACHE			
ANEMIA				HEART DISEASE			
ARTHRITIS				HEPATITIS			
ASTHMA				HIATAL HERNIA/REFLUX			
AUTOIMMUNE DISEASE (ex. LUPUS)				HIGH BLOOD PRESSURE			
BLEEDING DISORDERS				HIGH CHOLESTEROL			
BLOOD CLOTS IN LUNGS OR LEGS				INFERTILITY			
BLOOD TRANSFUSIONS				KIDNEY INFECTIONS			
BOWEL PROBLEMS				KIDNEY STONES			
CANCER				LIVER DISEASE			
CATARACTS				LUNG DISEASE			
CHICKENPOX				PNEUMONIA			
CONVULSIONS/SEIZURES/EPILEPSY				SEXUALLY TRANSMITTED DISEASE			
DES EXPOSURE				STROKE			
DIABETES				THYROID DISEASE			
EATING DISORDERS				TUBERCULOSIS			
FIBROIDS				ULCER			
GALL BLADDER DISEASE				OTHER			
GLAUCOMA							

PAST SURGERIES

NAME OF OPERATION	DATE	NAME OF OPERATION	DATE

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME	WHO PRESCRIBED	DRUG NAME	WHO PRESCRIBED

ALLERGIES

ALLERGY	TYPE OF REACTION	ALLERGY	TYPE OF REACTION

PATIENT HISTORY

MENSTRUAL HISTORY

Age periods began:	Periods come every _____ days	Number of days of bleeding: _____
Last Menstrual Period: / /	Typical flow: <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy	
How often do you need to change tampons/pads on day of heaviest flow: every _____ hour		
Do you have bleeding between periods?	How often has this occurred:	
Home pregnancy test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done		
Menopause status: <input type="checkbox"/> Pre Menopausal <input type="checkbox"/> Peri Menopausal <input type="checkbox"/> Post Menopause		
Age of menopause:		
Present method of birth control:		
Place a check next to any other methods you have used:		
<input type="checkbox"/> Pills <input type="checkbox"/> Foam/Other spermicidal <input type="checkbox"/> Withdrawal <input type="checkbox"/> Tubal Ligation <input type="checkbox"/> Diaphragm <input type="checkbox"/> Sponge <input type="checkbox"/> Natural family planning <input type="checkbox"/> Partner with vasectomy <input type="checkbox"/> Condom <input type="checkbox"/> IUD <input type="checkbox"/> Never		
If you want a birth control method, indicate which one:		
Have you taken hormones in the past? When:		
Name(s) of hormone(s) you have taken:		
Medicine taken for cramps:		
Describe any changes in your period over the last year:		

GYNECOLOGIC HISTORY

Is this your first pelvic exam? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last pelvic exam:	Date of last Pap test:
Have you had an abnormal Pap test? <input type="checkbox"/> No <input type="checkbox"/> Yes: When?		
What was done about it? <input type="checkbox"/> Repeated <input type="checkbox"/> Colposcopy <input type="checkbox"/> LEEP/Cone Biopsy <input type="checkbox"/> Laser		
Have you ever had sex? <input type="checkbox"/> No <input type="checkbox"/> Yes	Are you currently sexually active <input type="checkbox"/> No <input type="checkbox"/> Yes	
Sexual partners are <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both		
Check if you have ever had: <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Herpes <input type="checkbox"/> Syphilis <input type="checkbox"/> HPV(includes Venereal Warts)		
Do you experience <input type="checkbox"/> pain and or <input type="checkbox"/> bleeding during sexual activity? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have abnormal vaginal discharge or odor? <input type="checkbox"/> No <input type="checkbox"/> Yes For how long?		
Vaginal medications you have taken recently:		
Have you had a mammogram? <input type="checkbox"/> No <input type="checkbox"/> Yes Date of last mammogram:		
Have you had any breast lumps, tenderness, or discharge? <input type="checkbox"/> No <input type="checkbox"/> Yes When:		
What was done about it?		
Do you have PMS, hot flashes or menopausal symptoms?		
Do you have any defects of the uterus (like fibroids or abnormal shape)?		
Do you have a history of infertility?		
Do you have any questions?		
Physician/Nurse's Notes on History:		

PATIENT HISTORY

OBSTETRIC HISTORY

	Number		Number		Number
Pregnancies		Miscarriage		Abortions	
Premature births(<37 weeks)		Live Birth		Living Children	
How old are your children? Age:_____ Age:_____ Age:_____ Age:_____ Age:_____					
Any birth injuries or genetic problems?					
During and or after the pregnancy, did you have any problems/complications, like: <input type="checkbox"/> Diabetes <input type="checkbox"/> Excessive bleeding <input type="checkbox"/> Infection <input type="checkbox"/> Surgery <input type="checkbox"/> Hospitalization <input type="checkbox"/> Please Describe:					

FAMILY HISTORY

(Includes grandparents, parents, brothers, sisters, aunts, uncles and cousins)

ILLNESS	YES	LIST RELATIVE(S) AND AGE OF ONSET
Alzheimer's Disease		
Birth Defects		
Blood clots in lungs or legs		
Breast Cancer		
Colon Cancer		
Diabetes		
Drinking or Drug Problems		
Heart Disease		
Hepatitis		
High Blood Pressure		
High Cholesterol		
HIV/AIDS		
Mental Illness/Depression		
Osteoporosis (weak bones)		
Ovarian Cancer		
Stroke		
Tuberculosis		
Uterine Cancer		
Other		

Physician/Nurse's Notes on History:

PATIENT HISTORY

SOCIAL HISTORY

SUBSTANCE USE	NEVER	CURRENT	FORMER	AGE STARTED	AGE STOPPED	AMOUNT USED PER DAY
Alcohol						
Caffeine						
Cocaine						
IV Drug:						
Marijuana						
Narcotics						
Stimulants						
Tobacco						
Other						

OCCUPATION

<input type="checkbox"/> Desk Job, Mostly:
<input type="checkbox"/> Health Care Professional:
<input type="checkbox"/> Physical Job, Mostly:

EXERCISE

<input type="checkbox"/> Active, but no formal exercise	<input type="checkbox"/> Sedentary	<input type="checkbox"/> Minimal (once per week or less)
<input type="checkbox"/> Moderate (1-3 times per week)	<input type="checkbox"/> Heavy	<input type="checkbox"/> (4 or more times per week)

DOMESTIC VIOLENCE

<input type="checkbox"/> History of emotional abuse by	<input type="checkbox"/> spouse	<input type="checkbox"/> partner	<input type="checkbox"/> Other
<input type="checkbox"/> History of physical abuse by	<input type="checkbox"/> spouse	<input type="checkbox"/> partner	<input type="checkbox"/> Other
<input type="checkbox"/> History of sexual abuse by	<input type="checkbox"/> spouse	<input type="checkbox"/> partner	<input type="checkbox"/> Other
<input type="checkbox"/> Reported abuse to authorities:			
<input type="checkbox"/> Obtained professional counseling:			

PHYSICIAN/NURSE'S COMMENTS:

PATIENT HISTORY

REVIEW OF SYSTEMS

(Please check if applicable)

	PAST	1 ST VISIT	2 ND VISIT	3 RD VISIT	4 TH VISIT	5 TH VISIT
1.CONSTITUTIONAL						
CHANGE IN HEIGHT						
FATIGUE						
FEVER						
WEIGHT GAIN						
WEIGHT LOSS						
2.EYES						
VISION CHANGES						
GLASSES/CONTACTS						
3.EAR, NOSE & THROAT						
EAR ACHES						
RINGING IN EARS						
HEARING PROBLEMS						
SORE THROAT						
MOUTH SORES						
DENTAL PROBLEMS						
4.CARDIOVASCULAR						
CHEST PAIN OR PRESSURE						
DIFFICULTY BREATHING ON EXERTION						
SWELLING OF LEGS						
RAPID OR IRREGULAR HEART BEAT						
5.RESPIRATORY						
WHEEZING						
SPITTING OF BLOOD						
SHORTNESS OF BREATH						
CHRONIC COUGH						
6.GASTROINTESTINAL						
FREQUENT DIARRHEA						
BLOODY STOOL						
NAUSEA/VOMITING/INDIGESTION						
CONSTIPATION						
INVOLUNTARY LOSS OF GAS OR STOOL						
7.GENITAL						
ABNORMAL BLEEDING						
PAINFUL PERIODS						
PREMENSTRUAL SYNDROME (PMS)						
PAINFUL INTERCOURSE						
ABNORMAL VAGINAL DISCHARGE						

PATIENT HISTORY

	PAST	1 ST VISIT	2 ND VISIT	3 RD VISIT	4 TH VISIT	5 TH VISIT
INFERTILITY						
LUMP / MASS/LESION						
STD CONCERNS OR EXPOSURE						
8.BREAST						
PAIN IN BREAST						
NIPPLE DISCHARGE						
LUMPS						
ABNORMAL CHANGE IN BREAST SIZE						
9.BLADDER/URINARY						
BLOOD IN URINE						
PAIN WITH URINATION						
STRONG URGENCY TO URINATE						
FREQUENT URINATION						
INVOLUNTARY/UNINTENDED URINE LOSS						
URINE LOSS WHEN COUGHING OR LIFTING						
10.MUSCULOSKELETAL						
MUSCLE WEAKNESS						
JOINT PAIN						
MUSCLE PAIN						
11.SKIN						
RASH/ITCHING						
SORES						
DRY SKIN						
MOLES (GROWTH OR CHANGES)						
12. NEUROLOGIC						
DIZZINESS						
SEIZURES						
NUMBNESS OR TINGLING						
TROUBLE WALKING						
MEMORY PROBLEMS						
FREQUENT OR SEVERE HEADACHE						
13.ENDOCRINE						
HAIR LOSS						
ABNORMAL HAIR GROWTH						
COLD INTOLERANCE						
HEAT INTOLERANCE						
HOT FLASHES						
NIGHT SWEATS						
ABNORMAL THIRST						
14.PSYCHIATRIC						
DEPRESSION OR FREQUENT CRYING						

PATIENT HISTORY

	PAST	1 ST VISIT	2 ND VISIT	3 RD VISIT	4 TH VISIT	5 TH VISIT
ANXIETY						
PANIC ATTACK						
INSOMNIA						
15. HEMATOLOGIC						
FREQUENT BRUISES						
EASY BLEEDING						
ENLARGED LYMPH NODE (GLANDS)						
16 ALLERGIC/IMMUNOLOGIC						
SINUS ALLERGY SYMPTOMS						
ALLERGIC DERMATITIS						
ENVIRONMENTAL ALLERGIES						
MEDICATION ALLERGIES:						
LIST:						
OTHER:						

FORM COMPLETED BY:

1ST VISIT: PATIENT NURSE PRACTITIONER PHYSICIAN OTHER

2ND VISIT: PATIENT NURSE PRACTITIONER PHYSICIAN OTHER

3RD VISIT: PATIENT NURSE PRACTITIONER PHYSICIAN OTHER

4TH VISIT: PATIENT NURSE PRACTITIONER PHYSICIAN OTHER

5TH VISIT: PATIENT NURSE PRACTITIONER PHYSICIAN OTHER

ANNUAL REVIEW OF HISTORY BY PATIENT:

DATE REVIEWED:	SIGNATURE OF PATIENT:	PHYSICIAN/NURSE SIGNATURE:
1 ST VISIT:		
2 ND VISIT:		
3 RD VISIT:		
4 TH VISIT:		
5 TH VISIT:		