Women's Health Associates

Patient Information Form

Date:_____

Name: _____ **DOB:** _____

Medications

Please include any vitamins or supplements you are taking.

Medication	Dose	Frequency (i.e. 1 time per day)

Past Medical History

Please include date of the occurrence.

PCP: _____

Other Providers: _____
_____
_____

__ Alcohol Addiction ___/___/___
__ Anemia ___/___/___
__ Anxiety ___/___/___
__ Asthma ___/___/___
__ Blood clots ___/___/___
__ Bipolar ___/___/___
__ Breast Disease ___/___/___
__ Cancer ___/___/___
Type:_____
__ Chronic bronchitis ___/___/___
__ Circulatory disease ___/___/___
__ COPD ___/___/___
__ Crohn's Disease ___/___/___
__ Depression ___/___/___
__ Other ___/___/___
_____

__ Diabetes Type I ___/___/___
__ Diabetes Type II ___/___/___
__ Emphysema ___/___/___
__ Esophageal reflux ___/___/___
__ Gallstones ___/___/___
__ Heart Disease ___/___/___
__ Liver Disease ___/___/___
__ Other heart problems ___/___/___
Type _____
__ Heart failure ___/___/___
__ Hepatitis ___/___/___
__ High blood pressure ___/___/___
__ High cholesterol ___/___/___
__ Irritable bowel syndrome ___/___/___
__ Other ___/___/___
_____

__ Kidney Stones ___/___/___
__ Kidney Disease ___/___/___
Type _____
__ Migraines ___/___/___
__ Osteoporosis ___/___/___
__ PTSD ___/___/___
__ Rheumatoid Arthritis ___/___/___
__ Seizures/epilepsy ___/___/___
__ Sleep apnea ___/___/___
__ Stomach ulcer ___/___/___
__ Stroke (CVA) ___/___/___
__ Tuberculosis ___/___/___
__ Thyroid disease ___/___/___
Type: _____
__ Other ___/___/___
_____

Allergies

☐ **No known allergies**

Allergies	Reaction
1)	
2)	
3)	
4)	
5)	

Gynecological History

Periods: ___ every 28 days __ every month __ every 20-25 days __every 35-40 days Heavy days # of tampons____ # of pads____
Are you sexually active? Yes☐ No☐ If no, have you been in the past? Yes☐ No☐ If yes, with: Men __ Women __ Both __
Last pap smear date: ___/___/___ Have you ever had an abnormal pap smear? Yes ☐ No ☐ Date___/___/___
Have you had treatment for an abnormal pap smear? Colposcopy ___ LEEP ___ Cryotherapy ____ Date ___/___/___

Have you ever had a sexually transmitted disease? Yes ☐ No ☐ If yes, which type _____
Current Method of Birth Control: _____
Age of first period: _____ Any PMS symptoms Yes ☐ No ☐ If yes, which type_____

Menopause age of onset: _____ Painful periods? Yes ☐ No ☐ Duration of periods_____

Hysterectomy ___/___/___ Reason:_____ Treatment for infertility? Yes ☐ No ☐

Last mammogram ___/___/___ Last annual exam ___/___/___ Are you transgender? Yes ☐ No ☐

Obstetric History

How many times have you been pregnant? _____ Any multiple births? _____ Number of living children: _____

Year	Weeks	C-section/ Vaginal/or Miscarriage	Hours of Labor	Sex	Weight	Anesthesia	Complications	Name of Baby

Female Surgical History

__ Total abdominal hysterectomy with/without removal of ovaries ___/___/___
__ Vaginal Hysterectomy with/without removal of ovaries ___/___/___
__ D and C (Dilation and Curettage) ___/___/___
__ Cesarean Section ___/___/___
__ Leep/Cone Biopsy ___/___/___
__ Endometrial Ablation ___/___/___
__ Bilateral Tubal Ligation/Other sterilization ___/___/___

__ Laparoscopy ___/___/___
__ Myomectomy ___/___/___
__ Reduction Mammoplasty ___/___/___
__ Augmentation Mammoplasty ___/___/___
__ Mastectomy ___ Right ___ Left ___/___/___
__ Breast Biopsy ___/___/___
__ Other _____

Surgical History

__ Angioplasty ___/___/___
__ Appendectomy ___/___/___
__ Arthroscopy Knee ___/___/___
__ Back Surgery ___/___/___
__ Coronary Artery Bypass Graft ___/___/___
__ Carpal Tunnel Release ___/___/___
__ Cataract Extraction ___/___/___
__ Colonoscopy ___/___/___

__ Colostomy ___/___/___
__ Gallbladder ___/___/___
__ Gastric Bypass ___/___/___
__ Hernia Repair ___/___/___
__ Hip Replacement ___/___/___
__ Knee Replacement ___/___/___
__ LASIK ___/___/___
__ Liver biopsy ___/___/___

__ Laparoscopy ___/___/___
__ Open Reduction Internal Fixation ___/___/___
__ Oral Surgery/Wisdom Teeth Extraction ___/___/___
__ Pacemaker ___/___/___
__ Small Bowel Resection ___/___/___
__ Thyroidectomy ___/___/___
__ Tonsillectomy ___/___/___
__ Other ___/___/___
_____

Hospitalizations

Date	Reason
__/___/___	
__/___/___	
__/___/___	
__/___/___	

Family History

☐ **Adopted**

	Alive/ Deceased/ Unknown	Year of Birth	Age	Significant family medical history
Father				
Daughter (s)				
Son (s)				
Spouse				
Mother				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Paternal uncle				
Paternal aunt				
Maternal uncle				
Maternal aunt				
Siblings				

Social History

check any that apply

Are you a smoker? ___ Current ___ Former ___ Non Smoker
If current smoker amount a day: ___Light (1-9) ___Moderate (10-19) ___Heavy(20-39) ___Very Heavy (40+)
Tobacco use other than smoking: ___Vaping ___ E Cigarettes ___Chew ___Dip ___Patch
Occupation:
___Full Time __Part Time __Retired __Unemployed __Student __Homemaker __Works at home __Self Employed
Type of Work: _____
Marital Status:
__ Married __Never Married __Separated __Divorced __Widowed __Single __Relationship with Male __Relationship with Female
Do you want to discuss previous or current physical, sexual or emotional abuse with your provider? Yes☐ Please notify No☐

Drugs: Yes☐ No☐ Recovering☐ If you take recreational drugs what type: _____
Caffeine: ___ Cups per day ___ Soda per day Alcohol: __Rare __No __Yes __Socially __Daily __Occasionally
Prescription Drug Use: Yes☐ No☐ Recovering☐
Exercise: Yes☐ No☐ Frequency:_____ Amount of time: _____ Travel outside US? Yes☐ No☐ Where? _____
Pets: Yes☐ No☐ Type: _____ Legal Problems: Yes☐ No☐ Type: _____

Health Maintenance

Annual/Wellness exam	___Yes ___No	___/___/___
Childhood Immunizations	___Yes ___No	
Date of Last Lab	___Yes ___No	___/___/___
DEXA scan (Bone Density)	___Yes ___No	___/___/___
Gardasil (HPV) Series	___Yes ___No	___/___/___
Influenza vaccine	___Yes ___No	___/___/___
Pneumococcal vaccine	___Yes ___No	___/___/___
Stool cards for hidden blood	___Yes ___No	___/___/___
Tetanus vaccine	___Yes ___No	___/___/___

Additional Comments:

_____
_____
_____
_____

_____ _____
Signature **Date**

Office Use Only

Provider reviewed Initials: _____ Date _____

Data keyed in eCW Initials: _____ Date _____

Check the chart for abnormal pap history, mammogram, and DEXA.

Last Pap _ _/_ _/_ _

Pap Negative
Pap Positive (circle one) LSIL HSIL ASCUS ASCUS – H
High Risk HPV (circle one) Positive Negative Not Done

Abnormal Pap _ _/_ _/_ _

Pap (circle one) LSIL HSIL ASCUS ASCUS – H
Colposcopy (circle one) ECC Negative Not Done
Biopsy (circle one) Negative CIN1 CIN2 CIN3
Leep (circle one) Negative CIN1 CIN2 CIN3 (If Top Hat Done)
Cryo/ELF

For abnormal pap and OB History sort from Oldest to Newest in the system.