



INITIAL WOMEN'S HEALTH ASSESSMENT

Please fill out this questionnaire as completely as possible. The information provided will become part of your medical records and is totally confidential. This information will assist us in our effort to provide quality health care.

Name: (Last) (First) (Middle Initial) DOB: Date:

Please note the reason for your visit today?
What is your occupation/what do you do for a living?
Who referred you?

Primary Care Provider Phone #
PCP Address

ALLERGIES:

Please note any allergies or reactions to medications or other agents.
Medication: Reaction:
Medication: Reaction:
Medication: Reaction:

CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS:

Please include any medications you currently take including DOSAGE and INSTRUCTIONS.
Med/Dose/Instr:
Med/Dose/Instr:
Med/Dose/Instr:
Med/Dose/Instr:
Med/Dose/Instr:

GYNECOLOGIC STATUS

Menstrual History: (skip to next section if you are Post-Menopausal)

Date your last period began: Was it normal?
How often are your periods? How many days do your periods last?
Flow: heavy average light
Do you think you have a problem with your period?
If yes, Explain:

Birth Control:

What method of birth control, if any are you using?
Are you satisfied with your current method? Yes If No, Why

Post-Menopausal: (skip if you are pre-menopausal)

Post-Menopausal since age: Have you ever been on Hormone Replacement Therapy?
Why or Why not?
If so, for how long? Are you experiencing any vaginal bleeding?

Sexual History:

Are you sexually active? No Yes Are your partner(s) male female
Do you or your partner have more than one partner? No Yes I don't know

GYNECOLOGIC HISTORY

Have you had any of the following: (please circle all the apply)

- Ovarian cyst
- Polycystic ovaries
- Abnormal uterine structure
- Fibroid uterus
- Endometriosis
- Abnormal pap
- Infertility

MEDICAL HISTORY

Do you have any major medical problems? No Yes: _____

Have you ever had or been diagnosed with: (please circle all the apply)

- Cancer
- Heart murmur
- High blood pressure
- High cholesterol
- Heart attack or angina
- Stroke
- Phlebitis/blood clots
- Pulmonary embolus
- Asthma
- Ulcers
- Gall bladder disease
- Hepatitis/jaundice
- Irritable bowel
- Colitis
- Thyroid Disease
- Diabetes
- Anemia**
- Sickle Cell Trait
- TB (tuberculosis)
- seizures
- Migraines
- Depression
- Alcoholism
- Drug addiction
- Osteoporosis
- Arthritis
- Kidney problems
- Other _____

Pap Smear History:

Date of last pap smear: _____

Have you had abnormal pap smears? No Yes, Date & Result _____

Date of last mammogram: _____ Date of last colonoscopy: _____

SURGICAL/HOSPITALIZATION HISTORY:

List all hospitalization, operations or major injuries (excluding pregnancy):

DATE	HOSPITALIZATIONS, OPERATIONS, OR MAJOR INJURIES

OBSTETRICAL HISTORY:

Have you ever been pregnant? No yes

If yes, how many times have you been pregnant? (including miscarriages and abortions) _____

How many children do you have? _____

Please list all pregnancies below

Pregnancy Outcome (Vaginal, C-Section, VBAC, miscarriage, ectopic, induced abortion)	Date (or year if unsure)	How far along were you?	Problems or Complications

Do you smoke cigarettes? never formerly currently