WOMEN'S HEALTH CLINIC

FOR OFFICE USE ONLY

HT	BP	RR
WT	HR	PAIN

Please fill in EVERY blank. If the question does not apply to you, please write N/A.

NAME:_____BIRTH DATE:_____TODAY'S DATE:_____

Preferred Phone #:_____ Home/Cell/Work/Other OK to leave a Message? Yes / No

Secondary Phone #:_____ Home/Cell/Work/Other OK to leave a Message? Yes / No

Which doctor are you here to see? (Circle One) Kinder / Phillips / Runnels / Hirsch / Bunton

Place of Employment and phone # _____

Primary Care Physician _____

Reason for Visit: (Annual / Pregnancy / Problem)_____

Preferred Pharmacy (Name/Street/Phone#):_____

_____

Preferred Lab (VERIFY WITH YOUR INSURANCE COMPANY): _____

Medication Allergies? (Circle one) Yes / No If yes, list allergy and reaction: _____

List any medications you are currently taking, including vitamins and supplements:

Name / Strength / Frequency:	Name / Strength / Frequency:

Are you currently pregnant? (Circle one) Yes / No

How many times have you been pregnant including miscarriages, ectopic pregnancies, and abortions? _____

How many children do you have living at this time? _____

#	Baby's Birth date	Baby's sex & weight *(Circle one)*	Delivery: Vaginal or C-Section *(Circle one)*	Laceration/ Episiotomy *(Circle one)*	Weeks pregnant at delivery	Number of hours in labor	Miscarriage/ Abortion	Ectopic	Location (Hospital)	Your age at delivery
1		M / F weight: ___	Vaginal / C-section	Y / N						
2		M / F weight: ___	Vaginal / C-section	Y / N						
3		M / F weight: ___	Vaginal / C-section	Y / N						
4		M / F weight: ___	Vaginal / C-section	Y / N						
5		M / F weight: ___	Vaginal / C-section	Y / N						
6		M / F weight: ___	Vaginal / C-section	Y / N						

Please explain any other problems with previous pregnancies other than what is listed above.

_____

_____

Signature _____

Please fill in EVERY blank. If the question does not apply to you, please write N/A.

NAME:_____BIRTH DATE:_____

Age of first period? _____ **What was the first day of your last period?_____**

Are your periods (Circle one) Regular / Irregular / Absent **Are your periods bothersome?** (Circle one) Yes / No

Have you ever had sex? (Circle one) Yes/ No **Are you currently sexually active?** (Circle one) Yes/ No

Sexual orientation: (Check one) ○ Heterosexual (opposite sex) ○ Homosexual (same sex) ○ Bi-sexual

Do you practice safe sex? (Circle one) Yes/ No / Sometimes

What type of birth control do you use? (Check one)

○ None ○ Birth control pills ○ Condoms ○ Nuvaring ○ Patch ○ Depo provera (injection)

○ IUD(Mirena or Paraguard) Date of insert_____ ○ Implanon or Nexplanon Date of insert_____

○ Hysterectomy ○Tubal ligation ○Vasectomy ○ Rhythm method/Natural family planning ○ Other _____

Have you received Gardasil series of injections? (Circle one) Yes / No

Date of last pap smear? _____Normal / Abnormal **Date of last mammogram?** _____ Normal / Abnormal

Do you agree to a blood transfusion if necessary? (Circle one) Yes / No

Please Circle YES or NO, Every box must be answered.

History of abnormal PAP Smear	Y / N	Hepatitis	Y / N
Anemia	Y / N	Hypercoagulable Disorder	Y / N
Asthma	Y / N	High Cholesterol	Y / N
Autoimmune Disease	Y / N	High Blood Pressure	Y / N
Bartholin's Gland Cyst	Y / N	Incompetent Cervix	Y / N
Blood Transfusion	Y / N	Infertility	Y / N
Breast Cancer	Y / N	Liver Disease	Y / N
Breast Mass	Y / N	Phlebitis	Y / N
Bruising / Bleeding Disorder	Y / N	Ovarian Cancer	Y / N
Cerebrovascular Accident (CVA)	Y / N	Ovarian Cyst	Y / N
Cervical Cancer	Y / N	Pelvic Inflammatory Disease (PID)	Y / N
Clotting Disorder	Y / N	Polycystic Ovarian Syndrome (POS)	Y / N
Congenital Heart Disease	Y / N	Prolapsed Uterus	Y / N
Depression	Y / N	Premature Rupture of Membranes	Y / N
DES Exposure	Y / N	Psychiatric Disease	Y / N
Diabetes Mellitus	Y / N	Pulmonary Embolism (PE)	Y / N
Drug / Alcohol use	Y / N	Seizures	Y / N
Endometriosis	Y / N	Thyroid Disease	Y / N
Uterine Fibroids	Y / N	Tuberculosis (TB)	Y / N
Gallbladder Disease	Y / N	Uterine Cancer	Y / N
Genital Herpes/ Exposure / Histoy	Y / N	Urinary Tract Infection (UTI)	Y / N
Heart Murmur	Y / N	Vaginal infection	Y / N
Hemoglobinopathy	Y / N	Sexually Transmitted Disease (STD)	Y / N

Please list any other medical conditions if not included in above list.

_____

_____

Signature _____

Please fill in EVERY blank. If the question does not apply to you, please write N/A.

NAME:_____BIRTH DATE:_____

List ALL past surgeries and procedures:

Type/Year:	**Type/Year:**
Type/Year:	**Type/Year:**
Type/Year:	**Type/Year:**

Family History

Disease	Circle one	If yes, please indicate which family member and age of diagnosis	Disease	Circle one	If yes, please indicate which family member and age of diagnosis
Alcoholism	Y / N		Diabetes	Y / N	
Asthma	Y / N		Down Syndrome	Y / N	
Autoimmune Disorder	Y / N		Hemophilia-A	Y / N	
Breast Cancer	Y / N		High Cholesterol	Y / N	
Cervical Cancer Uterine/Endometrial Cancer	Y / N Y/ N		High Blood Pressure	Y / N	
Coagulopathy	Y / N		Mental Illness	Y / N	
Colon Cancer	Y / N		Mental Disability	Y / N	
Congenital Heart Disease	Y / N		Muscular Dystrophy	Y / N	
Coronary Artery Disease (CAD)	Y / N		Ovarian Cancer	Y / N	
Cerebrovascular Accident (CVA)	Y / N		Seizure Disorder	Y / N	
Cystic Fibrosis (CF)	Y / N		Sickle Cell Anemia	Y / N	
Depression	Y / N		Spina Bifida	Y / N	
Developmental Delay	Y / N		Thyroid Disease	Y / N	

Please list any other medical conditions if not included in above list.

_____

_____

Signature _____

Please fill in EVERY blank. If the question does not apply to you, please write N/A.

Name: _____ Birth Date: _____

Religious Affiliation _____

Are you adopted? (Circle one) Yes or No

Race (Circle one) White / Black / Asian / Hispanic / Other _____

What country were you born in_____

Primary Language? _____Are you right or left handed? _____

Highest level of education? _____ Occupation_____

Current marital status? (Circle one) Single / Married / Separated /Divorced / Widowed / Life Partner

Military Background? (Circle one) Yes / No If yes, what branch of service _____

Currently (Circle one) Active Duty / Reserves / Retired / Veteran

Do you drink alcohol? (Circle one) Yes / No

If yes, how often: (Circle one) Daily / Weekly / Monthly / Yearly / Occasionally / Rarely / Socially

Do you drink caffeine? (Circle one) Yes / No If yes, How many cups per day? _____

Do you smoke? (Circle one) Yes / No / Former_____(Quit date) If yes, How many? _____

Do you vape? (Circle one) Yes / No / Former_____(Quit date) If yes, How often? _____

Do you use recreational drugs? (Circle one) Yes / No

Any recent changes in sleep pattern? (Circle one) Yes / No

Do you exercise? (Circle one) Yes / No If yes, How often? _____

What kind of diet do you eat? (Circle one) Regular / Vegetarian / Other _____

Do you have animals in your home? (Circle one) Yes / No

If yes, what type of animal? _____

Have you recently traveled out of state? (Circle one) Yes / No

Have you recently traveled out of the country? (Circle one) Yes/ No

(Circle one)

Have you fallen in the last year?	Yes	No
Do you have firearms in your home?	Yes	No
Do you wear your seat belt?	Yes	No
Smoke detector in home?	Yes	No
Carbon monoxide detector in home?	Yes	No
Radon in home?	Yes	No
Pool / Spa at home?	Yes	No

Signature: _____