Women's Health Specialists of Bossier

PATIENT NAME: _____ DOB:_____

TODAY'S DATE: _____

REASON FOR VISIT: ☐ WELL-WOMAN ☐ OB CARE ☐ GYN Problem (Please list details) _____

PREFFERED PHARMACY: _____ PHARMACY LOCATION: _____

PRIMACY CARE PHYSICIAN: _____ ALLERGIES: _____

LIST ALL CURRENT MEDICATIONS (INCLUDING BIRTH CONTROL) OR ATTACH MEDICATION LIST:_____

_____☐ **SEE MEDICATION LIST**

HAVE YOU RECEIVED THE INFLUENZA (FLU) VACCINE IN THE LAST YEAR? ☐ Yes ☐ No

HAVE YOU RECEIVED THE **COVID-19 VACCINE**? ☐ Yes ☐ No

HAVE YOU RECEIVED THE PNEUMONIA VACCINE IN THE LAST 5 YEARS? **(>65 YEARS OLD)** ☐ Yes ☐ No ☐ N/A

PAIN SCALE: 0 1 2 3 4 5 6 7 8 9 10 SITE: _____

GYNECOLOGICAL HISTORY:

DATE OF LAST MENSTRUAL PERIOD: _____ LENGTH OF CYCLE:_____ FLOW: ☐Light ☐Medium ☐Heavy

DAYS BETWEEN YOUR PERIODS: _____ DO YOU HAVE A PERIOD EVERY MONTH? ☐ Yes ☐ No

HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST PERIOD?_____ IF POST MENOPAUSAL, AGE AT MENOPAUSE: _____

CURRENT BIRTH CONTROL METHOD: (Includes vasectomy, tubal ligation, condoms, IUD, Shots, pills, patches, rings or NONE):

_____

IF OVER 40 YEARS OLD: DATE OF LAST MAMMOGRAM: _____

IF OVER 50 YEARS OLD: DATE OF LAST COLONOSCOPY:_____ BONE DENSITY TEST: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING SEXUALLY TRANSMITTED DISEASES?

HPV: ☐Yes ☐No SYPHILIS: ☐Yes ☐No HERPES: ☐Yes ☐No HIV: ☐Yes ☐No GONORRHEA: ☐Yes ☐No

CHLAMYDIA: ☐Yes ☐No TRICHOMONAS: ☐Yes ☐No

OBSTETRIC HISTORY:

HOW MANY TIMES HAVE YOU BEEN PREGNANT? _____ HOW MANY LIVING CHILDREN DO YOU HAVE? _____

If applicable: HOW MANY MISCARRIGES HAVE YOU HAD? _____ HAVE YOU EVER HAD AN ABORTION? YES NO

RECORD OF PAST PREGNANCIES:

Date of delivery OR miscarrige	Term delivery or preterm delivery (weeks gestation)	Baby's birth weight	Sex of baby	Anesthesia (spinal block, epidural, etc)	Complications

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SOCIAL HISTORY:

CIRCLE ONE: SINGLE MARRIED ENGAGED DOMESTIC PARTNER TOGETHER SEPERATED WIDOWED

SEXUAL ORIENTATION (CIRCLE ONE): HETEROSEXUAL HOMOSEXUAL BISEXUAL Other (Please describe): _____

SEXUALLY ACTIVE: ☐ YES ☐ NO

HIGHEST GRADE LEVEL YOU COMPLETED: _____

WHAT KIND OF WORK DO YOU DO?: _____ NAME OF EMPLOYER: _____

NAME OF BABY'S FATHER (IF APPLICABLE): _____

WHAT KIND OF WORK DOES YOUR PARTNER DO? (IF APPLICABLE): _____

EXERCISE LEVEL: ☐None ☐Occasional ☐ Moderate ☐ Heavy **DIET:** _____

CAFFIENE INTAKE: ☐None ☐Daily CUPS PER DAY: _____

SMOKING/VAPE HISTORY: ☐Never ☐Former ☐Occasional ☐Daily PACK(S)/PODS PER DAY: _____ HOW MANY YEARS: _____

ALCOHOL INTAKE: ☐Never ☐Occasional ☐Daily **CURRENT OR FORMER DRUG USE?** ☐ Yes ☐ No

LIST ANY STREET DRUGS/ILLEGAL SUBSTANCES USED IN THE LAST YEAR: _____

DO YOU USE A SEATBELT ROUTINELY? ☐ Yes ☐ No DO YOU USE SUNCREEN ROUTINELY? ☐ Yes ☐ No

WHO LIVES WITH YOU? _____ NUMBER OF CHILDREN IN THE HOUSE: _____

HAVE ANY OF YOUR FAMILY MEMBERS HAD THE FOLLOWING CONDITIONS? (Please specify maternal or paternal side of family and relation to you. Example: Paternal side, aunt; Maternal side, grandmother; brother/sister)

	YES	MOTHER (M) FATHER (F) Relation to you		YES	MOTHER (M) FATHER (F) Relation to you
Anesthesia Complications			Heart Problems		
Anxiety Disorder			Hepatitis		
Asthma			High Blood Pressure		
Bipolar Disorder			High Cholesterol		
Birth Defects or Inherited Disease			Kidney Disease		
Breast Cancer			Mental Retardation (chromosome disorders)		
Breast Problems			Osteoporosis		
Cancer			Ovarian Cancer		
Cervical Cancer			Pulmonary Embolism		
Cystic Fibrosis			Seizures/Epilepsy		
Depression			Sicke Cell Disease or Trait		
Diabetes			Stroke		
Diverticulitus			Tay Sachs		
Endometriosis			Thalassemia		
Fibroids			Thyroid Problems		
Fragile X			Uterine Cancer		
Heart Disease			Varicose Veins		

SURGERIES: (Pleast list type of surgery and aporoximate year including C-Sections, Tubal Ligation, D&C, Bladder Suspension, etc.)

SURGERY TYPE	SURGERY YEAR

PATIENT NAME: _____ DOB:_____

OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?

Little interest or pleasure in doing things	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Feeling down, depressed, or hopeless	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Trouble falling asleep or staying asleep, or sleeping too much	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Feeling tired or having little energy	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Poor appetite or overeating	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Trouble concentrating on things, such as reading or watching television	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Moving or speaking slowly or the opposite – more fidgety or restless than usual	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Thoughts that you would be better off dead and/or hurting yourself in some way	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

HAVE <u>YOU</u> HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

	YES		**YES**
Abnormal Pap Smear		Heart Disease	
Anemia		Heart Problems	
Anesthesia Complications		Hepatitis	
Anxiety Disorder		High Blood Pressure	
Asthma		High Cholesterol	
Bipolar Disorder		Hyperthyroidism	
Birth Defects/Inherited Diseases		Hypothyroidism	
Bladder or Kidney Problems		Infertility	
Blood Disease		Kidney Disease	
Breast Problems		Liver Disease	
Cancer		Lung Disease	
Cervical Cancer		Muscle, Joint or Bone	
COPD		Osteoporosis	
Cystic Fibrosis		Ovarian Cancer	
Depression		Pulmonary Embolism	
Diabetes		Seizures/Epilepsy	
Diverticulitis		Sicke Cell Diease	
Endometriosis		Sickle Cell Trait	
Fibroids		Stroke	
Fibromyalgia		Tay Sachs	
GERD/Reflux		Thalassemia	
GI Problems		Thyroid Problems	
Hearing Problems		Uterine Cancer	
Headaches		Varicose Veins	
Migraines		Vision or Eye Problems	

PATIENT SIGNATURE: _____ DATE: _____