DATE COMPLETED: Doylestown Women's Health Center

PATIENT NAME:_____DOB_____ OCCUPATION:_____

ADDRESS:_____

PRIMARY CARE PHYSICIAN:_____PCP PHONE#_____

PCP FAX#_____ PHARMACY:_____

In order for us to provide quality care to you, we ask that you fill in the answers to the questions below. All answers will be kept confidential. We'd like you to feel comfortable about discussing any questions and concerns you have with your doctor or nurse.

Reason for your visit?

Allergies (medicine,food,other)	Reactions? (Rash, itching, swelling?)

Medications (List all medicines that you take, how, much, and how often?)

GYN HISTORY:

Date of last period: / / Interval between periods: How many days do you bleed?

Do you have any urinary problems? □ NO □ YES

Any abnormal bleeding? □ NO □ YES

Any pelvic pain? □ NO □ YES

Any abnormal discharge? □ NO □ YES

Do you have symptoms of Menopause? □ NO □ YES

Do you do self-breast exams monthly? □ NO □ YES

Do you take calcium supplements? □ NO □ YES

Are you sexually active? □ NO □ YES

Have you changed partners? □ NO □ YES

Do you use condoms? □ NO □ YES

What method of birth control do you use? □ None

Have you received Gardasil? Dates Given: 1st: 2nd: 3rd:_____

I received a hand out on HPV □ NO □ YES

Have you been treated for sexually transmitted disease? □ NO □ YES

□ Gonorrhea □ Herpes □ Chlamydia□ HPV □ Syphilis □ hepatitis □ HIV □ other

Do you wish to be tested for any sexually transmitted disease or HIV/AIDS? □ NO □ YES

WHEN WAS THE LAST TIME YOU HAD ANY OF THE FOLLOWING : (give approximate date)

Mammogram? / /	Where?
Sigmoid/Colon exam? / /	Where?
Stool check for blood? / /	Where?
Complete Physical? / /	Where?

Since your last visit list any OB History/Surgeries/Hospitalizations (include OB history) Immunizations:

SINCE YOUR LAST VISIT PLEASE CIRCLE IF YOU HAVE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING

□ High blood Pressure □ Breathing Problems □ Blood Disorders □ Alcohol Abuse □ Phlebitis □ Liver Disease
□ Diabetes □Thyroid Problems □Blood transfusions □ Drug Abuse □ Heart Problems
□ Osteoporosis □ Cancer (Gyn, Breast, Colon, other_____) □ Breast Problems □ Depression
□ Kidney Problems □ Migraine Headaches □other

Has anyone in your family been diagnosed with the following:

□ Cancer (Gyn, Breast, Colon other) WHO?

□ Any serious illness WHO?

SOCIAL HISTORY

Marital Status? Single□ Married □ Divorced □ Widowed □

Do you feel threatened by your current relationship? □ NO □ YES

Do you use tobacco products?
Please circle NEVER Former, last used on_____ Currently, how many packs per day_____

Do you drink alcohol?	□ NO □ YES	IF "YES" how often?	What kind?	How Much?
Do you use drugs?	□ NO □ YES	IF "YES" how often?	What kind?	How Much?
Do you exercise regularly?	□ NO □ YES	IF "YES" how often?	What kind?	How Much?

I understand that all tests ordered for me may not be covered by my insurance company.

Patient Signature: _____

Reviewed by: _____

Date:_____ Acct#_____ Doctor:_____