DOYLESTOWN WOMEN'S HEALTH CENTER

PATIENT NAME:
DOB:
EMERGENCY NAME AND PHONE:
DATE COMPLETED:

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:		**COMMENTS**
Date of last period:	/ /	Interval between periods:
Age when period began:	Yrs. old	
Do you have loss of urine?	□ NO	□ YES
Do you have any urinary problems?	□ NO	□ YES
Any history of abnormal PAP smears?	□ NO	□ YES If "yes", any treatment? YES NO
Any abnormal bleeding?	□ NO	□ YES
Any pelvic pain?	□ NO	□ YES If "yes", any treatment? YES NO
Any abnormal discharge?	□ NO	□ YES
Do you have symptoms of Menopause?	□ NO	□ YES
Do you take hormonal replacement?	□ NO	□ YES
Do you do self-breast exams monthly?	□ YES	□ NO
Do you take calcium supplements?	□ YES	□ NO

SEXUAL HISTORY

Are you sexually active? □ Yes □ No Heterosexual □ Yes □ No Homosexual □ Yes □ No Bisexual □ Yes □ No

Have you had multiple sexual partners?	□ NO	□ YES How many?
Do you use condoms?	□ NO	□ YES
What method of birth control do you use?		□ None
Have you been treated for sexually transmitted disease?	□ NO	□ Gonorrhea □ Herpes □ Chlamydia □ HPV □ Syphilis □ Hepatitis □ HIV □ Other
Have you ever been tested for HIV/AIDS?	□ NO	□ YES
Do you wish to be tested for any sexually transmitted disease?	□ NO	□ YES

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

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

OB History/Surgeries/Hospitalizations (include OB history) Immunizations since your last visit:

OB HISTORY

Delivery Date	Vaginal/C-Section	Baby's sex & weight	Birth place	Complications	Current Health of children

Number of miscarriages: Number of abortions:

PLEASE TURN OVER AND COMPLETE OTHER SIDE

DOYLESTOWN WOMEN'S HEALTH CENTER

LIST ALL SURGERIES AND APPROXIMATE DATES:	
	/ /
	/ /
	/ /
	/ /
	/ /
LIST ALL REASONS FOR HOSPITALIZATIONS AND APPROXIMATE DATES:	
	/ /
	/ /
	/ /

PLEASE CHECK IF YOU HAVE EVER HAD ANY OF THE FOLLOWING:

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

HAS ANYONE IN YOUR FAMILY BEEN DIAGNOSED WITH THE FOLLOWING:

☐ Cancer (Gyn, Breast, Colon other)	WHO?	☐ Thyroid Disease	WHO?
☐ Osteoporosis	WHO?	☐ Seizures	WHO?
☐ High Blood Pressure	WHO?	☐Genetic Disease ( )	WHO?
☐ Heart Disease	WHO?	☐ Bleeding Disorder	WHO?
☐ Diabetes	WHO?	☐ Autoimmune Disorder	WHO?

Is your mother alive? ☐ YES ☐ NO (Age at Death) Is you father alive? ☐ YES ☐NO (Age at Death)

SOCIAL HISTORY

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Present Occupation?

Have you worked with chemicals, paint, asbestos, leads or other hazardous materials? ☐ No ☐ Yes

How many people live with you now?

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

PERSONAL HABITS

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" →	What kind? How Often?
Do you use drugs?	☐ NO ☐ YES	IF "YES" →	What kind? How Often?
Do you exercise regularly?	☐ YES ☐ NO	IF "YES" →	What kind? How Often?
Do you have a "Living Will"?	☐ YES ☐ NO	Are you an organ donor?	☐ YES ☐ NO

Do you feel safe at home? YES NO
Do you wear seatbelts when driving or riding in a vehicle? YES NO

Patient Signature: _____ Date:_____
Reviewed by: _____ Date:_____