CENTRAL PHOENIX WOMEN'S HEALTH CARE

NAME:_____ Age:_____ Height:_____ Weight _____

Date _____ Reason For Visit Today _____

PAST MEDICAL HISTORY

☐	Anemia	☐	Glaucoma	☐	HIV	☐	Ulcers
☐	Arthritis/ Joint Pain	☐	Heart Disease	☐	Kidney Infections	☐	Yellow jaundice
☐	Asthma	☐	Heart Murmur	☐	Kidney Stones	☐	Other List Below
☐	Blood Transfusions	☐	Hepatitis	☐	Seizures/convulsions/epilepsy		_____
☐	Depression/Anxiety	☐	High Cholesterol	☐	Thyroid Disease		_____
☐	Diabetes	☐	High Blood Pressure	☐	Tuberculosis		_____

GYNECOLOGY HISTORY

☐ Chlamydia ☐ Gonorrhea ☐ Genital Warts ☐ Herpes ☐ Syphilis ☐ Vaginosis ☐ Trichomonas

What is the date of your last pap smear? _____

Have you ever had an abnormal Pap smear test? Yes ☐ No ☐ If yes when _____

Do you consider yourself: ☐ Straight/Heterosexual ☐ Bisexual ☐ Lesbian, gay or homosexual

☐ Something else (please specify)_____

Current Gender Identity: ☐ Female ☐ Male ☐ Transgender ☐ Add'l category (please specify)_____

IMMUNIZATIONS

Tetanus	Yes	☐	No	☐	Date: _____	HPV	Yes ☐	No ☐	Date: _____	
Flu Shot	Yes	☐	No	☐	Date: _____					

PAST SURGERIES

Past Surgery	Date	Past Surgery	Date

CURRENT MEDICATIONS / HERBS / VITAMINS / NUTRITIONAL SUPPLEMENTS

DRUG NAME	DOSAGE	DRUG NAME	DOSAGE

MEDICATION ALLERGIES / FOOD ALLERGIES

Drug Allergies	Reaction	Drug Allergies	Reaction

Are you allergic to Peanuts? Yes ☐ No ☐ Are you allergic to eggs? Yes ☐ No ☐

FAMILY MEDICAL HISTORY

Condition:	Yes	Relative / Age	Mother's Side	Father's Side
Alcoholism				
Breast Cancer				
Colon Cancer				
Diabetes				
High Blood Pressure				
Heart disease				
Ovarian Cancer				
Stroke				
Other:				

REPRODUCTIVE HISTORY

Age at First Menstral Period _____ Period Frequency _____ Duration of Flow _____ (days)

Date of Last Menstral Period (LMP) _____ Flow: Light Normal Heavy

Current Birth Control Method _____ Age at Menopause (if applicable) _____

Do you have sex with ☐ Men ☐ Women ☐ Both ☐ Virgin ☐ Not sexually active

Obstetrical History: #No. of Pregnancies _____ Miscarriages_____ Abortions_____ Living Children_____

Delivery Date	Weeks	Birth weight	Sex	Delivery Type	Complications

SOCIAL HISTORY

Smoking	Yes ☐	No ☐	Packs per Day _____	Years _____	Age when quit _____			
Alcohol	Yes ☐	No ☐	Drinks per Day _____	Drinks per Week _____				
Drug Use	Yes ☐	No ☐	Regular Exercise	Yes ☐	No ☐	Seat Belt Use	Yes ☐	No ☐

PERSONAL SAFETY

Yes ☐	No ☐	Has anyone close to you ever threatened to hurt you?
Yes ☐	No ☐	Has anyone ever hit, kicked, choked, or hurt you physically?
Yes ☐	No ☐	Has anyone, Including your partner, ever forced you to have sex?
Yes ☐	No ☐	Are you ever afraid of your partner?

PLEASE CHECK (X) IF ANY OF THE FOLLOWING SYMPTOMS APPLY TO YOU CURRENTLY

CONSTITUTIONAL
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Fatigue

EYES
- ☐ Double vision
- ☐ Spots before eyes
- ☐ Vision changes

EARS, NOSE, THROAT
- ☐ Ear aches
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Mouth sores
- ☐ Dental problems

BREASTS
- ☐ Pain in breast
- ☐ Discharge
- ☐ Masses

CARDIOVASCULAR
- ☐ Painful breathing
- ☐ Chest pain
- ☐ Difficult breathing on exertion
- ☐ Swelling of legs
- ☐ Palpitations of heart

RESPIRATORY
- ☐ Wheezing
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Cough, chronic

GASTROINTESTINAL
- ☐ Frequent diarrhea
- ☐ Bloody stool
- ☐ Nausea/vomiting
- ☐ Constipation

GENITOURINARY
- ☐ Blood in urine
- ☐ Pain with urination
- ☐ Urgency
- ☐ Frequency of urination
- ☐ Incomplete emptying
- ☐ Stress incontinence
- ☐ Abnormal periods
- ☐ Painful intercourse

SKIN
- ☐ Rash
- ☐ Ulcers

NEUROLOGIC
- ☐ Dizziness
- ☐ Seizures
- ☐ Numbness
- ☐ Trouble walking

MUSCULOSKELETAL
- ☐ Muscle weakness

ENDOCRINE
- ☐ Dry skin
- ☐ Abnormal thirst
- ☐ Hot flashes

PSYCHIATRIC
- ☐ Depression
- ☐ Frequent crying

HEMATOLOGIC/LYMPHATIC
- ☐ Easy bruising
- ☐ Enlarged lymph nodes
- ☐ Easy bleeding

Patient Signature _____ Date _____

Date Reviewed: ____/____/____ Patient Signature:_____ MD initials _____

Date Reviewed: ____/____/____ Patient Signature:_____ MD initials _____

Date Reviewed: ____/____/____ Patient Signature:_____ MD initials _____

1-8-19