Metro Partners in Women's Health

Patient Information

Please help us by giving some information about your health.
Please complete **both** sides and fill in **all** spaces. **Please print.**

Name_____Birth date_____Age_____Today's date_____

Primary Care Doctor_____Other physicians treating you_____

Current medications_____

_____

Medication allergies_____Other allergies_____Latex allergy_____

Reason for your visit_____

Past GYN History	
Last menstrual period:	
Age when periods began:	
Length of periods:	
How many days between periods?	
Do you do self breast exams?	
	Results:
Last pap smear:	
Last Mammogram:	
Last Bone density test:	
Last colonoscopy:	

Current birth control/family planning method:	Are you sexually active?
How many sexual partners in the past year:	Are you trying to get pregnant?

OB History
Total pregnancies:
Number of living children:
Number of miscarriages:
Number of voluntary terminations:
Number of C-Sections:
Number of vaginal deliveries:
Number of tubal pregnancies:
Complications:

Social History	No	Yes	Comments
Do you smoke?			
Amount per day:			
Do you drink alcohol?			
Amount per day?			
Have you used drugs?			
Do you exercise?			
Do you use a seat belt?			
Have you been emotionally, sexually, or physically abused?			

Medical problems (such as diabetes, high blood pressure, thyroid problems or problems with heart, lung or kidney)?_____

_____

Any past surgeries?_____

_____

Regarding <u>your</u> health, please review the following list of health problems and describe any "yes" answers:

	No	Yes
General/Constitutional		
Fatigue		
Fever		
Weight gain		
Weight loss		
Ophthalmologic		
Vision changes		
Cataracts		
Glaucoma		
ENT		
Hearing loss		
Balance problems		
Hoarseness		
Difficulty swallowing		
Sore throat		
Endocrine		
Thyroid problems		
Hormone imbalance		
Diabetes		
Steroids		
Respiratory		
Difficulty breathing		
Chronic cough		
Blood in sputum		
Cardiovascular		
Chest pain		
High cholesterol		
Irregular heartbeat		
Shortness of breath		

	No	Yes
Gastrointestinal		
Rectal pain		
Hemorrhoids		
Hernia		
Indigestion		
Abdominal pain		
Blood in stool		
Constipation		
Diarrhea		
Nausea		
Vomiting		
Hematology		
Chemotherapy		
Anemia		
Blood disorders		
Easy bruising		
Women Only		
Chlamydia/Gonorrhea		
Vaginal odor		
Nipple discharge		
Breast lump		
Breast pain		
Heavy periods		
Hot flashes		
Pain with intercourse		
Vaginal discharge		
Genitourinary		
Blood in urine		
Pain with urination		
Urgency		
Frequency		
Involuntary loss of urine		

	No	Yes
Musculoskeletal		
Arthritis		
Back pain		
Leg pain		
Pain in joints		
Peripheral Vascular		
Swelling in legs/feet		
Skin		
Hair loss		
Venereal warts/Herpes		
Mole(s)		
Rash		
Skin cancer		
Neurologic		
Lupus		
Stroke		
Memory problems		
Dizziness		
Fainting		
Headache		
Seizures		
Psychiatric		
Depression		
Phobias		
Anxiety		

Is there any family history in colon, uterine, breast, ovarian, or pancreatic cancer?	**No / Yes**
Are you of Ashkenazi Jewish ancestry?	**No / Yes**

Family Health Problems:

Review the following list of health problems and check yes if they apply to parents, grandparents, siblings, aunts, uncles, or your children.

	No	Yes	If Yes, Please Indicate Maternal(Mother) or Paternal (Father) Relative	Age when diagnosed	Alive or Deceased?
Diabetes					
Heart Disease					
Osteoporosis					
High Blood Pressure					
Stroke					
Blood clots					
Endometriosis					
Colon cancer					
Breast cancer					
Uterine Cancer					
Ovarian cancer					
Endometrial cancer					
Birth Defects					
Other					