



WOMEN'S MEDICAL GROUP

Name: _____ Age: _____ Date: _____

Marital Status: _____ Occupation: _____ First day of your last period: _____

Primary Care MD: _____ Menopause Hysterectomy

I. **List any problems or concerns you are having:** _____

II. List other physicians you have seen **since your last visit.** None

Name of Doctor _____ Date _____ Problem _____

III. List any surgeries or hospitalization **since your last visit.** None

Type of surgery or reason for hospitalization _____ Date _____ Doctor _____ Facility _____

IV. (A) Current contraception: None Vasectomy Tubal Ligation Hysterectomy IUD Condoms Rhythm

Diaphragm Depo-Provera Norplant Pills: Brand _____ Other _____

(B) Do you have any concerns about sexually transmitted diseases? Yes No

(C) Current medications and dosage: (Include over-the-counter, herbal, and vitamins) None

(D) Medication allergies: None _____

V. Since your last visit, have you had a problem with:

	Yes	No		Yes	No		Yes	No
1. Abnormal periods	<input type="checkbox"/>	<input type="checkbox"/>	11. Black or bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	21. Visual changes	<input type="checkbox"/>	<input type="checkbox"/>
2. Bleeding between periods	<input type="checkbox"/>	<input type="checkbox"/>	12. Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	22. Muscle or skeletal problems	<input type="checkbox"/>	<input type="checkbox"/>
3. Bleeding after intercourse	<input type="checkbox"/>	<input type="checkbox"/>	13. Frequent urinary infections	<input type="checkbox"/>	<input type="checkbox"/>	23. Hepatitis, jaundice or gall bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
4. Severe pain with periods	<input type="checkbox"/>	<input type="checkbox"/>	14. Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>			
5. Breast mass or lumps	<input type="checkbox"/>	<input type="checkbox"/>	15. Leakage of urine	<input type="checkbox"/>	<input type="checkbox"/>			
6. Breast secretions	<input type="checkbox"/>	<input type="checkbox"/>	16. Crushing chest pains	<input type="checkbox"/>	<input type="checkbox"/>			
7. Blood from nipples	<input type="checkbox"/>	<input type="checkbox"/>	17. Palpitations	<input type="checkbox"/>	<input type="checkbox"/>			
8. Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	18. Shortness of breath at rest	<input type="checkbox"/>	<input type="checkbox"/>			
9. Extreme fatigue	<input type="checkbox"/>	<input type="checkbox"/>	19. Change in headaches	<input type="checkbox"/>	<input type="checkbox"/>			
10. Change in skin mole	<input type="checkbox"/>	<input type="checkbox"/>	20. Severe depression	<input type="checkbox"/>	<input type="checkbox"/>			

Other: _____

VI. Do you:

	Yes	No		Yes	No
Exercise regularly	<input type="checkbox"/>	<input type="checkbox"/>	Use recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>
Do monthly breast exams	<input type="checkbox"/>	<input type="checkbox"/>	Smoke	<input type="checkbox"/>	<input type="checkbox"/>
Wear helmets when you bike or ski	<input type="checkbox"/>	<input type="checkbox"/>	Drink alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Wear seatbelts	<input type="checkbox"/>	<input type="checkbox"/>	Amount _____		
			Have questions about domestic or sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>

VII. 1. When was your last mammogram? _____ SBC VRI Other: _____

2. When was your last bone density? _____ Los Olivos VRI Other: _____

3. Last Colonoscopy? _____ Where? _____

VIII. Family history: _____ Yes No

1. Since your last visit, have there been any deaths in your family? Yes No

2. Since your last visit, have there been any significant illness in the family? Yes No

3. Family history of cancer of the breast ovary uterus cervix colon?

4. Family history of osteoporosis diabetes heart attacks melanoma high cholesterol Alzheimer's thyroid disease

How would you like to be contacted with test results? mail home phone cell phone #: _____

ok to leave results on voice mail no results on machine Current email: _____

We are required to use a preventative care code for a Well-woman annual exam when a yearly pap smear is performed. Many, but not all, insurances will cover this type of visit.