WOMEN'S HEALTH CARE in SAN DIEGO, A.M.C.

*****COMPLETE PRIOR TO APPOINTMENT*****

Patient's Name: _____Date: _____

Date of Birth: _____Age:_____ Marital Status: _____

Occupation: _____

Allergies: _____ Reaction_____

Allergies: _____Reaction_____

Allergies: _____Reaction_____

Preferred Pharmacy: _____

Gynecologic History

MENSES	Date	Yes	No	Physician's Notes
Length of periods (days of bleeding):				
Frequency of periods:				

SEXUAL ACTIVITY

Have you ever had sex?				
Present birth control/ Method:				

STD

Any history of STD?: (Circle) Herpes, Warts, Chlamydia, Gonorrhea, Pelvic Infection				

PAP

When was your last pap smear?				
Results of last pap smear: NORMAL/ABNORMAL (circle one)				
Any history of abnormal paps?				

GYN

History of Endometriosis?				
History of Fibroids?				
History of Infertility?				

BREAST

History of Breast Biopsy?				
Date of last Mammogram:				
NORMAL/ABNORMAL (circle one)				

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Patient's Name: _____Date: _____ DOB: _____

MEDICAL HISTORY

1. General	❑ Sleep apnea	❑ Sleep Disorder	
2. Eyes	❑ Glaucoma		
3. ENT	❑ Sinus problems	❑ Chronic ringing in ears	
4. Heart	❑ Heart Disease ❑ High Blood Pressure	❑ Murmur ❑ High Cholesterol	❑ Heart Attack ❑ Congestive Heart Failure
5. Lung	❑ Asthma	❑ Emphysema/COPD	❑ Tuberculosis
6. GI	❑ Hepatitis or Yellow Jaundice ❑ Ulcers	❑ Chron's Disease/Colitis	❑ Irritable Bowel Syndrome
7. GU	❑ Renal Disease	❑ Recurrent Urine Infections	❑ Renal Stones
8. MS	❑ Arthritis ❑ Osteoporosis	❑ Chronic Back Pain ❑ Fibromyalgia	❑ Chronic Neck Pain
9. Neuro	❑ Stroke ❑ Headache/Migraines	❑ Seizure/Epilepsy	❑ Nerve Paralysis
10. Psych	❑ Depression ❑ Psychiatric illness	❑ Anxiety ❑ PMS	❑ Eating disorder
11. Heme	❑ Anemia ❑ Blood Clot in Legs or Lungs	❑ Bleeding Disorder	❑ Sickle Cell Disease
12. Skin	❑ Cancer Basal Cell	❑ Cancer Squamous Cell	❑ Melanoma
13. Endo	❑ Thyroid	❑ Diabetes	
14. Cancer	❑ Specify:		
15. Other	❑ Lupus	❑ Other Autoimmune disease	
16. Social	❑ Current Smoker #_____per day x___ years ❑ Past Smoker Quit _____ ❑ No. of alcholic drinks _____per week	❑ Recreational Drugs ❑ History of Domestic Violence Specify:	HIV/AIDS risk factors ❑ History of IV drug ❑ History of Blood trans ❑ Partner with Risks Rectal Intercourse

Other: _____

Patient Signature: _____ Doctor Signature: _____Date:_____

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Patient's Name: _____ **Date:** _____ **DOB:** _____

Obstetric History

		Number		Number		Number
Pregnancies			Abortions		Miscarriages	
Premature Births (<37 Weeks)			Live Births		Living Children	

	Birth Date	Weight at Birth	Baby's Sex	Weeks Pregnant	Type of Delivery (Vaginal, Cesarean, etc.)	Complications
1.						
2.						
3.						
4.						
5.						
6.						

Any history of depression before or after pregnancy? ☐ No ☐ Yes, How treated

Operations

Surgery	Date	Hospital

Major Illnesses/Hospitalizations/Cancer

Problem	Date	

Current Medications

Drug Name	Dosage	Who Prescribed	Drug Name	Dosage	Who Prescribed

Do You Use Medical Marijuana? ☐ **Yes** ☐ **No**

Family History – Any family members with the following problems?

Illness	Yes	Which Relative(s) and Age of Onset	Illness	Yes	Which Relative(s) and Age of Onset
Diabetes	☐		Hepatitis	☐	
Stroke	☐		Breast Cancer	☐	
Heart Disease	☐		Colon Cancer	☐	
Blood Clots in Lungs or Legs	☐		Ovarian Cancer	☐	
High Blood Pressure	☐		Uterine Cancer	☐	
High Cholesterol	☐		Bleeding Tendency	☐	
Osteoporosis	☐		Other	☐	

WOMEN'S HEALTH CARE IN SAN DIEGO

COMPLETE PRIOR TO APPOINTMENT

Patient's Name: _____ **DOB:** _____ **DATE:** _____

Reason for visit today: Annual or Problem (describe) _____

FIRST DAY OF LAST MENSTRUAL CYCLE: _____

Are you experiencing any of the following?

GENERAL
- ❑ Weight loss
- ❑ Weight gain
- ❑ Sleep abnormalities
- ❑ Fever
- ❑ Night sweats

EYES
- ❑ Blindness

HENT
- ❑ Sore throat
- ❑ Chronic sinus congestion

RESP
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Cough
- ❑ Bloody sputum

GYN
- ❑ Irregular cycles
- ❑ Bleeding between periods
- ❑ Bleeding after sex
- ❑ Painful periods
- ❑ Painful sex
- ❑ Decreased sex drive
- ❑ Hot flashes
- ❑ Vaginal itching
- ❑ Vaginal dryness
- ❑ Abnormal discharge
- ❑ New partner(s)
- ❑ Partner:___male ___female___both

STD testing?
- ❑ Test me ☐ Do not test me

CVS
- ❑ Chest pain
- ❑ Irregular heart beat
- ❑ Leg swelling

MSS
- ❑ Joint pain
- ❑ Joint swelling
- ❑ Back pain

BREAST
- ❑ Masses
- ❑ Nipple discharge
- ❑ Pain

NS
- ❑ Fainting
- ❑ Headache
- ❑ Migraines
- ❑ Seizures

GI
- ❑ Diarrhea
- ❑ Constipation
- ❑ Change in stool
- ❑ Blood in stool
- ❑ Abdominal pain
- ❑ Bloating
- ❑ Nausea
- ❑ Vomiting

SKIN
- ❑ New moles
- ❑ Skin ulcers

HEME
- ❑ Abnormal bleeding from surgeries/wounds

GU
- ❑ Blood in urine
- ❑ Pain with urination
- ❑ Frequent urination
- ❑ Unexpected loss of urine

PSYCH
- ❑ Depression
- ❑ Anxiety
- ❑ Eating disorder

Please indicate the preferred lab for specimens: ❒ SHARP ❒ LAB CORP ❒ QUEST ❒ OTHER

Pt. Sign. _____Date_____ MD. Sign _____