

Date: ____/____/____

SOUTHWEST WOMEN'S CARE, P.C.
HISTORY & PHYSICAL

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PATIENT FULL NAME: _____ D.O.B.: ____/____/____ AGE: ____ SEX: ____
HEIGHT: ____ WEIGHT: ____ SINGLE: ____ MARRIED: ____ DIVORCED: ____ WIDOWED: ____
YOUR OCCUPATION: _____ SPOUSE'S NAME: _____ OCCUPATION: _____

GYNECOLOGIC HISTORY

AGE AT FIRST MENSTRUAL PERIOD: _____ DATE OF LMP: ____/____/____
HOW OFTEN ARE YOUR PERIODS? _____ HOW LONG DO YOUR PERIODS LAST? _____
IS YOUR MENSTRUAL FLOW LIGHT: ____ MODERATE: ____ HEAVY: ____
DO YOU HAVE PAINFUL PERIODS? _____ DO YOU HAVE PELVIC PAIN OF ANY NATURE: _____

AGE AT MENOPAUSE: _____ ARE YOU ON HORMONE REPLACEMENT? _____
DO YOU TAKE CALCIUM SUPPLEMENTS? ____ WHAT TYPE AND HOW MUCH? _____
DO YOU EXERCISE REGULARLY? ____ HOW OFTEN? _____
WHAT EXERCISES DO YOU DO? _____

DATE OF LAST PAP SMEAR? ____/____/____ ANY HISTORY OF ABNORMAL PAP SMEAR? ____ WHEN? _____
WHAT TREATMENT DID YOU HAVE FOR ABNORMAL PAP? _____

ARE YOU SEXUALLY ACTIVE? ____ NUMBER OF SEXUAL PARTNERS: ____ DO YOU USE CONTRACEPTION? ____
IF SO, WHAT TYPE(S) AND NAME(S): _____
HAVE YOU EVER HAD A PELVIC INFECTION OR SEXUALLY TRANSMITTED DISEASE? _____
PLEASE INDICATE: GONORRHEA ____ CHLAMYDIA ____ SYPHILIS ____ HERPES ____ GENITAL WARTS (HPV) ____
HAVE YOU EVER BEEN PHYSICALLY OR SEXUALLY ABUSED? _____

DO YOU PRACTICE SELF BREAST EXAMS: ____ HOW OFTEN? _____ HAVE YOU DETECTED ABNORMALITIES? ____
DATE OF LAST MAMMOGRAM: ____/____/____ ANY HISTORY OF ABNORMAL RESULTS? _____

DO YOU HAVE ANY PROBLEMS WITH LEAKING URINE? ____ WHILE EXERCISING? ____ WHILE SNEEZING? ____
IF SO, WHEN AND HOW OFTEN? _____
DO YOU EVER HAVE TO WEAR A PAD FOR LEAKING URINE? _____

DID YOUR MOTHER TAKE DES WHEN SHE WAS PREGNANT WITH YOU? _____

PHYSICIAN NOTES: _____

OBSTETRICAL HISTORY

NO. OF PREGNANCIES: ____ NO. OF LIVING CHILDREN: ____ PREMATURE DELIVERIES: ____ MISCARRIAGES: ____
ABORTIONS: ____ PLEASE LIST DETAILS:

YEAR	WEEKS GESTATION	WEIGHT	SEX	DELIVERY TYPE	COMPLICATIONS

DATE: ____/____/____

PATIENT: _____

SURGICAL HISTORY

PAST SURGERIES/HOSPITALIZATIONS	DATE	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICAL HISTORY

DRUG ALLERGIES: _____

WHAT HAPPENS WHEN YOU TAKE THESE MEDICATIONS: _____

MEDICATIONS YOU ARE CURRENTLY TAKING (NAME & DOSE): _____

IMMUNIZATIONS

DATE OF LAST TETANUS: ____/____/____ INFLUENZA: ____/____/____ PNEUMOCOCCAL: ____/____/____

OTHERS: _____

DO YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

PLEASE CIRCLE YES OR NO

- | | | |
|-----------------------------------|------------------------------|--------------------|
| Y N WEIGHT LOSS OR GAIN | Y N HIGH BLOOD PRESSURE | Y N ANEMIA |
| Y N CHANGE IN APPETITE | Y N ELEVATED CHOLESTEROL | Y N TB EXPOSURE |
| Y N HEADACHES OR MIGRAINES | Y N ASTHMA OR ALLERGIES | Y N PHLEBITIS |
| Y N RECURRENT INFECTIONS | Y N BLOOD TRANSFUSION | Y N DIABETES |
| Y N MITRAL VALVE PROLAPSE | Y N JAUNDICE OR HEPATITIS | Y N KIDNEY DISEASE |
| Y N RHEUMATIC FEVER | Y N ULCERS OR BOWEL PROBLEMS | Y N DEPRESSION |
| Y N THYROID / ENDOCRINE DISORDERS | Y N ARTHRITIS OR LUPUS | Y N HEART DISEASE |
| Y N HIGH RISK FOR AIDS OR HIV | Y N NEUROLOGIC DISORDERS | Y N CANCER: _____ |

DO YOU SMOKE? _____ IF YES, HOW MANY PACKS PER DAY? _____ AGE STARTED: _____

HOW MANY CAFFEINATED DRINKS DO YOU DRINK PER DAY? _____

HOW MANY ALCOHOLIC DRINKS DO YOU DRINK PER DAY? _____ PER WEEK? _____ SOCIALLY? _____

DO YOU USE STREET DRUGS? _____ IF YES, HOW OFTEN: _____

EXPLANATION TO ANY OF THE ABOVE: _____

PHYSICIAN NOTES: _____

FAMILY HISTORY

PLEASE INDICATE RELATIONSHIP TO RELATIVE:

DIABETES: _____ BREAST CANCER: _____

HYPERTENSION: _____ UTERINE CANCER: _____

HEART DISEASE: _____ OVARIAN CANCER: _____

STROKE: _____ COLON CANCER: _____

OTHER INHERITED ABNORMALITIES: _____

REASON YOU ARE SCHEDULED TO SEE OUR DOCTOR TODAY: _____

PATIENT SIGNATURE: _____

DATE: ____/____/____