

SOUTHWEST WOMEN'S CARE

Baseline/Dobson
2204 S. Dobson Rd. Suite 202
Mesa, Arizona 85202

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Phoenix, Arizona 85048

HISTORY & PHYSICAL

PATIENT NAME: _____ D.O.B.: ____/____/____ AGE: ____ DATE: ____/____/____
SINGLE: ____ MARRIED: ____ DIVORCED: ____ WIDOWED: ____ YOUR OCCUPATION: _____

OFFICE USE: HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____

GYNECOLOGIC HISTORY

AGE AT FIRST MENSTRUAL PERIOD: _____ DATE OF LAST MENSTRUAL PERIOD: ____/____/____
HOW OFTEN ARE YOUR PERIODS? _____ HOW LONG DO YOUR PERIODS LAST? _____
IS YOUR MENSTRUAL FLOW LIGHT: YES NO MODERATE: YES NO HEAVY: YES NO
DO YOU HAVE PAINFUL PERIODS? YES NO DO YOU HAVE PELVIC PAIN OF ANY NATURE? YES NO

AGE AT MENOPAUSE: _____ ARE YOU ON HORMONE REPLACEMENT? _____
DO YOU TAKE CALCIUM SUPPLEMENTS? _____ WHAT TYPE AND HOW MUCH? _____
DO YOU EXERCISE REGULARLY? YES NO HOW OFTEN? _____
WHAT EXERCISE DO YOU DO? _____

DATE OF LAST PAP SMEAR: ____/____/____ ANY HISTORY OF ABNORMAL PAP SMEARS? YES NO
HPV YES NO WHEN? _____
WHAT TREATMENT DID YOU HAVE FOR ABNORMAL PAP? _____

ARE YOU SEXUALLY ACTIVE? YES NO DO YOU USE CONTRACEPTION? YES NO
IF SO, WHAT TYPE(S) AND NAME(S): _____
ANY HISTORY OF SEXUALLY TRANSMITTED DISEASE(S): YES NO IF SO, WHAT KIND: _____
WERE YOU TREATED: YES NO WITH WHAT MEDICATION: _____

DATE OF LAST MAMMOGRAM: ____/____/____ ANY HISTORY OF ABNORMAL RESULTS? YES NO
DO YOU PRACTICE SELF BREAST EXAMS? YES NO HOW OFTEN? _____

OBSTETRICAL HISTORY

NO. OF PREGNANCIES _____ NO. OF LIVING CHILDREN _____ MISCARRIAGES _____
NO. OF PREMATURE DELIVERIES (before 37 weeks) _____ NO. OF ABORTIONS _____
PLEASE LIST DETAILS:

YEAR	WEEKS GESTATION	WEIGHT	SEX	DELIVERY TYPE	COMPLICATIONS

SURGICAL HISTORY

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

PHYSICIAN NOTES: _____
02/23/2010 PAGE 1

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PATIENT NAME: _____

DATE: ____/____/____

PAST MEDICAL HISTORY

DRUG ALLERGIES: _____

WHAT HAPPENS WHEN YOU TAKE THESE MEDICATIONS: _____

MEDICATIONS YOU ARE CURRENTLY TAKING, STRENGTH, DOSAGE: _____

CARDIOVASCULAR:

PRIOR MYCARDIAL INFARCTION YES NO CORONARY ARTERY DISEASE YES NO
CONGESTIVE HEART FAILURE YES NO ESSENTIAL HYPERTENSION YES NO
HYPERLIPIDEMIA YES NO MITRAL VALVE PROLAPSE YES NO
HEART DISEASE YES NO

ENDOCRINE:

DIABETES MELLITUS TYPE I YES NO DIABETES MELLITUS TYPE II YES NO
OBESITY YES NO THYROID DISORDERS YES NO
HYPERTHYROIDISM YES NO HYPOTHYROIDISM YES NO

RESPIRATORY:

ALLERGIC RHINITIS YES NO ASTHMA YES NO
ACUTE BRONCHITIS YES NO COPD YES NO

IMMUNE/OTHER:

HIV YES NO

GASTROENTEROLOGY:

ESOPHAGITIS CHRONIC REFLUX YES NO HEPATITIS YES NO

GENITOURINARY:

PYELONEPHRITIS YES NO URINARY TRACT INFECTION YES NO
RENAL DISORDERS YES NO RENAL FAILURE YES NO

MUSCULOSKELETAL:

OSTEOARTHRITIS YES NO LUMBAGO (LOW BACK PAIN) YES NO
OSTEOPOROSIS YES NO

PSYCHIATRIC:

ANXIETY DISORDERS YES NO DEPRESSION YES NO

NEUROLOGICAL:

STROKE SYNDROME (CVA) YES NO MIGRAINES YES NO

