

WOMEN'S HEALTH EVALUATION

Chart # _____

DATE _____

NAME _____

BIRTH DATE _____

ADDRESS _____

APARTMENT # _____

CITY _____

STATE _____

ZIP CODE _____

HOME NUMBER _____

WORK NUMBER _____

CELL NUMBER _____

EMAIL ADDRESS _____

EMPLOYER _____

INSURANCE CARRIER _____

NAME OF SPOUSE/PARTNER _____

PHONE NUMBER _____

EMERGENCY CONTACT _____

PHONE NUMBER _____

HOW DID YOU LEARN ABOUT OUR CLINIC? _____

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST, OR APPLIES OFTEN

1 CONSTITUTIONAL	CURRENTLY	PAST	NOTES
Weight loss	<input type="radio"/>	<input type="radio"/>	
Weight gain	<input type="radio"/>	<input type="radio"/>	
Fever	<input type="radio"/>	<input type="radio"/>	
Fatigue	<input type="radio"/>	<input type="radio"/>	

2 EYES	CURRENTLY	PAST	NOTES
Double vision	<input type="radio"/>	<input type="radio"/>	
Spots before eyes	<input type="radio"/>	<input type="radio"/>	
Vision changes	<input type="radio"/>	<input type="radio"/>	

3 ENT/MOUTH	CURRENTLY	PAST	NOTES
Ear aches	<input type="radio"/>	<input type="radio"/>	
Ringing in ears	<input type="radio"/>	<input type="radio"/>	
Sinus problems	<input type="radio"/>	<input type="radio"/>	
Sore throat	<input type="radio"/>	<input type="radio"/>	
Mouth sores	<input type="radio"/>	<input type="radio"/>	
Dental problems	<input type="radio"/>	<input type="radio"/>	

4 CARDIOVASCULAR	CURRENTLY	PAST	NOTES
Painful breathing	<input type="radio"/>	<input type="radio"/>	
Chest pain	<input type="radio"/>	<input type="radio"/>	
Difficult breathing on exertion	<input type="radio"/>	<input type="radio"/>	
Swelling of legs	<input type="radio"/>	<input type="radio"/>	
Palpitations of heart	<input type="radio"/>	<input type="radio"/>	

CHART # _____

REVIEW OF SYSTEMS, CONTD.

5 RESPIRATORY	CURRENTLY	PAST	NOTES
Wheezing	<input type="radio"/>	<input type="radio"/>	
Spitting up blood	<input type="radio"/>	<input type="radio"/>	
Shortness of breath	<input type="radio"/>	<input type="radio"/>	
Chronic cough	<input type="radio"/>	<input type="radio"/>	

6 GASTROINTESTINAL	CURRENTLY	PAST	NOTES
Frequent diarrhea	<input type="radio"/>	<input type="radio"/>	
Bloody stool	<input type="radio"/>	<input type="radio"/>	
Nausea/vomiting	<input type="radio"/>	<input type="radio"/>	
Constipation	<input type="radio"/>	<input type="radio"/>	

7 GENITOURINARY	CURRENTLY	PAST	NOTES
Blood in urine	<input type="radio"/>	<input type="radio"/>	
Pain with urination	<input type="radio"/>	<input type="radio"/>	
Urgency	<input type="radio"/>	<input type="radio"/>	
Frequency of urination	<input type="radio"/>	<input type="radio"/>	
Incomplete emptying	<input type="radio"/>	<input type="radio"/>	
Loss of urine with coughing	<input type="radio"/>	<input type="radio"/>	
with laughing	<input type="radio"/>	<input type="radio"/>	
with position changes	<input type="radio"/>	<input type="radio"/>	
Abnormal periods	<input type="radio"/>	<input type="radio"/>	
Painful intercourse	<input type="radio"/>	<input type="radio"/>	
Excessive cramping	<input type="radio"/>	<input type="radio"/>	
Excessive bleeding	<input type="radio"/>	<input type="radio"/>	
PMS	<input type="radio"/>	<input type="radio"/>	
Infertility	<input type="radio"/>	<input type="radio"/>	
Medications for infertility	<input type="radio"/>	<input type="radio"/>	
Endometriosis	<input type="radio"/>	<input type="radio"/>	
Genital warts	<input type="radio"/>	<input type="radio"/>	
Vulvar lesions or cancer	<input type="radio"/>	<input type="radio"/>	
Abnormal Pap smears	<input type="radio"/>	<input type="radio"/>	
Colposcopy (cervical biopsies)	<input type="radio"/>	<input type="radio"/>	
LEEP or cone biopsy	<input type="radio"/>	<input type="radio"/>	
Cryosurgery	<input type="radio"/>	<input type="radio"/>	
Uterine fibroids (myomas)	<input type="radio"/>	<input type="radio"/>	
Ovarian cysts	<input type="radio"/>	<input type="radio"/>	
Ovarian tumors	<input type="radio"/>	<input type="radio"/>	
Sexually transmitted diseases	<input type="radio"/>	<input type="radio"/>	Gonorrhea/Chlamydia/Herpes/Syphilis/HPV
Frequent vaginal infections	<input type="radio"/>	<input type="radio"/>	Yeast or bacterial infection
Decreased libido	<input type="radio"/>	<input type="radio"/>	

Age at first period _____ years

Frequency of periods every _____ days

Length of periods _____ days

Date of last pap smear _____

Age at menopause _____

REVIEW OF SYSTEMS, CONTD.

	CURRENTLY	PAST	NOTES
8 MUSCULOSKELETAL			
Muscle weakness	<input type="radio"/>	<input type="radio"/>	
Joint pain	<input type="radio"/>	<input type="radio"/>	
<hr/>			
9 SKIN/BREASTS			
Pain in breasts	<input type="radio"/>	<input type="radio"/>	
Breast discharge	<input type="radio"/>	<input type="radio"/>	
Breast masses	<input type="radio"/>	<input type="radio"/>	
Skin rash	<input type="radio"/>	<input type="radio"/>	
Ulcers	<input type="radio"/>	<input type="radio"/>	
Cancer	<input type="radio"/>	<input type="radio"/>	
<hr/>			
10 NEUROLOGICAL			
Dizziness	<input type="radio"/>	<input type="radio"/>	
Seizures	<input type="radio"/>	<input type="radio"/>	
Numbness	<input type="radio"/>	<input type="radio"/>	
Trouble walking	<input type="radio"/>	<input type="radio"/>	
<hr/>			
11 PSYCHIATRIC			
Depression	<input type="radio"/>	<input type="radio"/>	
Frequent crying	<input type="radio"/>	<input type="radio"/>	
Anxiety	<input type="radio"/>	<input type="radio"/>	
Excessive anger	<input type="radio"/>	<input type="radio"/>	
<hr/>			
12 ENDOCRINE			
Dry skin	<input type="radio"/>	<input type="radio"/>	
Abnormal thirst	<input type="radio"/>	<input type="radio"/>	
Hot flashes	<input type="radio"/>	<input type="radio"/>	
<hr/>			
13 HEMATOLOGIC/LYMPHATIC			
Frequent bruising	<input type="radio"/>	<input type="radio"/>	
Cuts that do not stop bleeding	<input type="radio"/>	<input type="radio"/>	
Enlarged lymph nodes	<input type="radio"/>	<input type="radio"/>	
<hr/>			
14 ALLERGIC/IMMUNOLOGIC			
Allergies to medications	<input type="radio"/>	<input type="radio"/>	
Allergies to foods	<input type="radio"/>	<input type="radio"/>	
Allergies to latex or any metal	<input type="radio"/>	<input type="radio"/>	
Hay fever	<input type="radio"/>	<input type="radio"/>	

PERSONAL PAST HISTORY

MAJOR ILLNESSES	YES	NO
Asthma	<input type="radio"/>	<input type="radio"/>
Pneumonia	<input type="radio"/>	<input type="radio"/>
Chronic lung disease	<input type="radio"/>	<input type="radio"/>
Kidney infections/stones	<input type="radio"/>	<input type="radio"/>
Tuberculosis	<input type="radio"/>	<input type="radio"/>
Venereal disease	<input type="radio"/>	<input type="radio"/>
Heart trouble/murmur	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>
Rheumatic fever	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>
Ulcers	<input type="radio"/>	<input type="radio"/>
Depression/anxiety	<input type="radio"/>	<input type="radio"/>
Anemia/blood transfusions	<input type="radio"/>	<input type="radio"/>
Seizures/convulsions/epilepsy	<input type="radio"/>	<input type="radio"/>
Bowel troubles/colitis	<input type="radio"/>	<input type="radio"/>
Glaucoma	<input type="radio"/>	<input type="radio"/>
Arthritis/joint pain	<input type="radio"/>	<input type="radio"/>
Fractures	<input type="radio"/>	<input type="radio"/>
Hepatitis/yellow jaundice	<input type="radio"/>	<input type="radio"/>
Thyroid disease	<input type="radio"/>	<input type="radio"/>

OBSTETRICAL HISTORY

DATES

Number of pregnancies	_____	_____
Full term live births	_____	_____
Preterm live births (prior to 37 weeks gestation)	_____	_____
Stillbirth's	_____	_____
Miscarriages	_____	_____
Elective abortions	_____	_____
Number of living children	_____	_____

History of last six pregnancies (include any complications such as diabetes, hypertension, pre-eclampsia, hemorrhage, etc. . .)

DATE MONTH/ YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE OF DELIVERY	ANESTHESIA	PLACE OF DELIVERY	PRETERM LABOR YES/NO	CIRCUMCISION YES/NO	BREAST OR BOTTLE FED

CHART # _____

FAMILY HISTORY

ILLNESS	YES	RELATIVE(S)
Diabetes	<input type="radio"/>	_____
Stroke	<input type="radio"/>	_____
Heart disease	<input type="radio"/>	_____
High blood pressure	<input type="radio"/>	_____
Drinking problem or drug use	<input type="radio"/>	_____
Breast cancer	<input type="radio"/>	_____
Colon cancer	<input type="radio"/>	_____
Ovarian cancer	<input type="radio"/>	_____
Other cancers	<input type="radio"/>	_____
Other _____	<input type="radio"/>	_____

Comments _____

SOCIAL HISTORY

PERSONAL PROFILE

Marital status Married Single Widowed Divorced

Number of living children _____ Number of people in household _____

School completed High school College Graduate degree Other

Current or most recent occupation _____

HABITS

	YES	NO	
Smoking	<input type="radio"/>	<input type="radio"/>	_____ packs per day for _____ years
Alcohol	<input type="radio"/>	<input type="radio"/>	_____ drinks per day for _____ years
Drug use	<input type="radio"/>	<input type="radio"/>	Type of drug(s) _____
Seat belt use	<input type="radio"/>	<input type="radio"/>	
Regular exercise	<input type="radio"/>	<input type="radio"/>	Type of exercise _____
Anorexia or bulimia	<input type="radio"/>	<input type="radio"/>	When? _____

SEXUAL

Age at first intercourse _____

Number of partners in lifetime _____

Number of male partners _____ Number of female partners _____

Method of contraception _____

HISTORY OF USE

Rhythm	<input type="radio"/>
Birth control pills	<input type="radio"/>
Condoms	<input type="radio"/>
Depo-Provera	<input type="radio"/>
IUD (intrauterine device)	<input type="radio"/>
Diaphragm	<input type="radio"/>
Foams/jellies	<input type="radio"/>
Norplant	<input type="radio"/>

CHART # _____

What is the purpose of today's visit? _____

Health history completed by: Patient Office nurse Physician

Signature of patient _____

Date reviewed by physician with patient _____

Physician signature _____

Comments _____

