Women's Health Consultants, PLC
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History and Physical

Returning patient Information-Please help us by updating information about your health. **Complete both sides**.

Appointment Date _____
Name _____ Birthdate_____ Age _____
Marital Status_____ Primary Care Doctor_____
Reason for your visit _____

List **ALL MEDICATIONS** you take, including over the counter medications and vitamins. Include specific doses and when taken. Name Strength Frequency

_____ _____ _____
_____ _____ _____

Allergies_____

Date of Last period _____ Are your cycles light, normal or heavy flow? _____

Number of days of flow_____ How often are your periods? _____

Do you have cramps? _____ Any breast concerns? _____

When did you last have sex? _____ Have you had a new partner since your last exam? _____

How long have you been with your current partner? _____

Any history of rape or abuse? _____ if yes, when?_____

Method of birth control? (if applicable) _____

Complications of pregnancy or childbirth? _____

Are you a current or former smoker? _____ If current, how many cigarettes per day? _____

Do you use drugs? _____ If yes, what do you use? _____

Do you drink alcohol? _____How much? _____How often? _____

What type of work do you do? _____

Any new problems with your health? (such as diabetes, high blood pressure, thyroid problems etc.) _____

_____

Any surgeries since your last visit? _____

_____

Any other changes since your last visit? _____

OVER→ OVER→ OVER→

Have there been <u>any changes</u> to your family's health?

	Age	Diabetes	High blood pressure	Heart disease	Blood clots	Breast Cancer Ovarian Cancer	Colon cancer	Uterine cancer	Other
Father									
Mother									
Children									
Dad's Dad									
Dad's Mom									
Mom's Dad									
Mom's Mom									
Dad's siblings									
Mom's siblings									
Brother(s)									
Sister(s)									

Concerning your own health, are you experiencing any of these symptoms?

Symptom	**No**	**Yes**	**Symptom**	**No**	**Yes**
Fatigue			Nausea		
Fever			Vomiting		
Sleep disturbance			Painful urination		
Weight gain			Incontinence- leakage of urine		
Weight loss			Urgent urination		
Cold intolerance			Frequent urination		
Heat intolerance			Blood in Urine		
Constipation			Itching		
Abdominal pain			Acne		
Diarrhea			Headache		
Change in appetite			Seizures		
Blood in Stool			Anxiety		
			History of Depression		