Women's Health Consultants, PLC
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New Patient History and Physical

New patient Information-Please help us by giving some information about your health. **Complete both sides.**

Name _____ Today's date_____
Birthdate_____ Age _____ Referred by_____
Marital Status _____Primary Care Doctor _____
Preferred phone number to contact with results_____
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? _____

History of sexually transmitted disease_____

Have you ever had an abnormal pap smear? _____ If yes, when? _____

Date of last pap smear_____ Date of last mammogram_____

Date of last colonoscopy_____ Date of last bone density test _____

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) _____ Sexually active with men, women or both_____

Have you had Gardasil (HPV) vaccine? If so, how many injections_____

Number of pregnancies_____ Number of children_____ Number of miscarriages _____ Number of abortions_____

Any Ectopic pregnancies? _____Number of vaginal deliveries _____ Number of C-Sections_____

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? _____ If yes, How often? _____ How much?_____

What type of work do you do? _____

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

_____

Any surgeries in the past, or any history of anesthesia? _____

_____

Concerning 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									
Sister(s)									
Brother(s)									

Concerning your own health, are you currently 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		