

PHYSICIANS FOR WOMEN NEW PATIENT HISTORY FORM

NAME _____ DATE _____

HOW DID YOU HEAR ABOUT US? DOCTOR AD WEB PATIENT OTHER _____

• REASON FOR VISIT: _____

ALLERGIES(drugs, food, materials) _____

CURRENT MEDICATIONS: _____

LAST PAP SMEAR _____ NORMAL or ABNORMAL _____

FOLLOWUP ON ANY ABNORMAL PAPS _____

- GENERAL: no problems weight loss weight gain fever fatigue change in height
- RESPIRATORY: no problems painful breathing cough shortness of breath
- BREAST: no problems pain in breast nipple discharge lumps
LAST MAMMOGRAM _____
- CARDIOVASCULAR: no problems painful breathing chest pain or pressure
 difficulty breathing on exertion swelling of extremities rapid or irregular heartbeat
- GASTROINTESTINAL: no problems diarrhea constipation bloody stool abdominal pain
 nausea/vomiting indigestion involuntary loss of gas or stool
- GENITOURINARY: no problems
Age of menses _____, frequency of periods _____, type of birth control _____
 frequent urination blood in urine pain with urination urgency
 stress incontinence abnormal or painful periods painful intercourse
 abnormal bleeding from vagina abnormal vaginal discharge PMS
 DES exposure infertility
- MUSCULOSKELETAL: no problems Joint pain Muscle Pain
- PSYCHIATRIC: no problems anxiety change in sleep pattern depression
 inability to concentrate insomnia
- ENDOCRINE: no problems hot flashes hair loss abnormal thirst heat/cold intolerance
- HEMATOLOGY: no problems anemia easy bruising clotting disorder
- SEXUAL ORIENTATION: heterosexual homosexual bisexual

→BACK

PHYSICIANS FOR WOMEN NEW PATIENT HISTORY FORM

NAME _____ DATE _____

• PAST MEDICAL/SURICAL HISTORY:

Surgeries _____

Medical Conditions _____

Injuries _____

Immunizations _____

• FAMILY HISTORY:

Mother living deceased - cause: _____ age _____

Father living deceased - cause: _____ age _____

Siblings: No. living _____ No. deceased _____ causes/ages _____

Cancer in family _____

• PAST OB HISTORY: Pregnancies _____, Deliveries _____, Vaginal or c/section _____

miscarriages and/or abortions _____

Number living _____ Number deceased _____ causes/ages _____

• SOCIAL HISTORY:

Tobacco use _____ alcohol/drug use _____ seat belts _____ Diet _____

exercise _____ Vitamins/Herbs _____ Caffeine _____

PHYSICIANS FOR WOMEN ANNUAL HISTORY FORM

NAME _____ DATE _____

- REASON FOR VISIT: _____
 ALLERGIES(drugs, food, materials) _____
 CURRENT MEDICATIONS: _____

- GENERAL: NO change since ___/___/___ visit
 weight loss weight gain fever fatigue change in height

- RESPIRATORY: NO change since ___/___/___ visit
 painful breathing cough shortness of breath

- BREAST: NO change since ___/___/___ visit LAST MAMMOGRAM _____
 pain in breast nipple discharge lumps

- CARDIOVASCULAR: NO change since ___/___/___ visit
 painful breathing chest pain or pressure difficulty breathing on exertion
 swelling of extremities rapid or irregular heartbeat

- GASTROINTESTINAL: NO change since ___/___/___ visit
 diarrhea constipation bloody stool abdominal pain
 nausea/vomiting indigestion involuntary loss of gas or stool

- GENITOURINARY: NO change since ___/___/___ visit
 Age of menses _____, frequency of periods _____, type of birth control _____
 frequent urination blood in urine pain with urination urgency
 stress incontinence abnormal or painful periods painful intercourse
 abnormal bleeding from vagina abnormal vaginal discharge PMS
 DES exposure infertility

- MUSCULOSKELETAL: NO change since ___/___/___ visit
 Joint pain Muscle Pain

- PSYCHIATRIC: NO change since ___/___/___ visit
 anxiety change in sleep pattern depression
 inability to concentrate insomnia

- ENDOCRINE: NO change since ___/___/___ visit
 hot flashes hair loss abnormal thirst heat\cold intolerance

- HEMATOLOGY: NO change since ___/___/___ visit
 anemia easy bruising clotting disorder

→BACK

PHYSICIANS FOR WOMEN ANNUAL HISTORY FORM

NAME _____ DATE _____

- **SEXUAL ORIENTATION:** heterosexual homosexual bisexual
- **PAST MEDICAL\SURICAL HISTORY:** NO change since ___/___/___ visit
Surgeries _____
Medical Conditions _____
Injuries _____
Immunizations _____
- **FAMILY HISTORY:** NO change since ___/___/___ visit
Mother living deceased - cause: _____ age _____
Father living deceased - cause: _____ age _____
Siblings: No. living _____ No. deceased _____ causes/ages _____
Cancer in family _____
- **PAST OB HISTORY:** Pregnancies _____, Deliveries _____, Vaginal or c/section _____
miscarriages and/or abortions _____
Number living _____ Number deceased _____ causes/ages _____
- **SOCIAL HISTORY:**
Tobacco use _____ alcohol/drug use _____ seat belts _____ Diet _____
exercise _____ Vitamins/Herbs _____ Caffeine _____