Women's Health Consultants, PLC
46325 West 12 Mile Road
Suite 250
Novi, MI 48377

New Patient History and Physical

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

Appointment Date ________________________________

Name ____Birthdate_____________________________ Age ________

Marital Status ________________________Primary Care Doctor____

Preferred phone number to contact with results____

Reason for your visit ____

Referred by (**Name/Relationship**) ____

Current Medications ____

____

Allergies____

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

Number of days of flow__________ Do you have cramps? _________ Any breast concerns?_____________________

History of sexually transmitted disease____

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 the Gardasil 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? _________ How many cigarettes per day? ___________

Do you use drugs? _______ If so, what do you use?____

Do you drink alcohol? ______ How much? _______________________ How often? ___________________________

What type of work do you do? ____

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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									
Siblings									
Children									
Dad's Dad									
Dad's Mom									
Mom's Dad									
Mom's Mom									
Dad's siblings									
Mom's siblings									
Cousins (dad)									
Cousins (mom)									

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

Symptom	**No**	**Yes**	**Symptom**	**No**	**Yes**
Fatigue			Painful urination		
Fever			Incontinence		
Sleep disturbance			Urgent urination		
Weight gain			Joint stiffness		
Weight loss			Muscle aches		
Cold intolerance			Painful joints		
Excessive thirst			Acne		
Heat intolerance			Itching		
Abdominal pain			Changes in moles		
Constipation			Difficulty with balance		
Change in appetite			Headache		
Diarrhea			Seizures		
Nausea			Tremor		
Vomiting			Anxiety		
Frequent urination			History of depression		
Pain in lower back			Little pleasure or interest in doing things		
			Feeling down or depressed currently		