History and Physical

Women's Health Consultants, PLC
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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 ____

Current Medications ____

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Allergies____

Date of Last period _______________Number of days of flow_______ How heavy are your cycles? ____________________

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? ________________ 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? ____

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

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Any surgeries since your last visit? ____

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Any other changes since your last visit? ____

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Have there been any changes 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									
Cousins(dad)									
Cousins(mom)									

Concerning your own health, have you experienced 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		