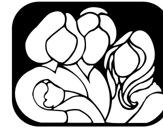
Date ____________________

NAME ____________________

NAME YOU PREFER TO BE CALLED ____________________



Carolina Women's Health Center, P.A.

Obstetrics-Gynecology-Infertility

WELCOME TO CAROLINA WOMEN'S HEALTH CENTER. PLEASE COMPLETE THE FOLLOWING AS COMPLETELY AND ACCURATELY AS POSSIBLE.

HAVE YOU EVER HAD:	**NO**	**YES**	**IF YES, DATE, DIAGNOSIS AND TREATMENT**
CANCER	❑	❑	
MRSA	❑	❑	
HEART PROBLEMS	❑	❑	
HIGH BLOOD PRESSURE	❑	❑	
HIGH CHOLESTEROL	❑	❑	
LUNG PROBLEMS	❑	❑	
DIABETES	❑	❑	
THYROID PROBLEMS	❑	❑	
SEIZURE DISORDER	❑	❑	
DEPRESSION, ANXIETY OR RELATED DISORDER	❑	❑	
BLEEDING DISORDER, ANEMIA	❑	❑	
KIDNEY DISEASE	❑	❑	
BONE, MUSCLE OR JOINT DISEASE	❑	❑	
BLADDER PROBLEMS (Multiple UTI's, Stress Incontinence)	❑	❑	
HEADACHES	❑	❑	
SURGERY:			
GYN (ON TUBES, OVARIES, UTERUS OR BREAST)	❑	❑	
CESAREAN SECTION	❑	❑	
ANY OTHER SURGERY (Tubes Tied, Breast Augmentation, Tonsils, Appendix, Gallbladder)	❑	❑	

LIST ALL MEDICATIONS, BOTH PRESCRIPTION AND OVER-THE-COUNTER. INCLUDE SUPPLEMENTS AND VITAMINS: PLEASE LIST NAME OF MEDICINE, DOSAGE AND PRESCRIBER:

MEDS ______ HOW MUCH(mg) ______ Who Gave it To You? ______ How many times a day do you take the med? ______

MEDS ______ HOW MUCH(mg) ______ Who Gave it To You? ______ How many times a day do you take the med? ______

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MEDS ______ HOW MUCH(mg) ______ Who Gave it To You? ______ How many times a day do you take the med? ______

LIST ALL DRUG ALLERGIES AND TYPE OF REACTION:

DRUG	REACTION

	NO	**YES**
LATEX ALLERGY	❑	❑
ALLERGIC TO SHELLFISH	❑	❑

LIST PREVIOUS IMMUNIZATIONS AND DATES:

	NO	**YES**	
GARDISIL	❑	❑	
INFLUENZA	❑	❑	
PHEUMOVAX	❑	❑	
TETANUS	❑	❑	
ZOSTAVAX	❑	❑	
HEPATITIS B	❑	❑	

HAVE YOU EVER HAD:			**DATE**	**LOCATION**	**RESULT**
MAMMOGRAM	❑	❑			
COLONOSCOPY	❑	❑			
BONE DENSITY TEST (DEXA)	❑	❑			

REPRODUCTIVE HISTORY

MENSTRUAL HISTORY:

AGE WHEN PERIODS STARTED________YRS. # DAYS BETWEEN PERIODS:__________DAYS. PERIOD DURATION:________DAYS OF BLEEDING.

FLOW: ❑LIGHT ❑MED ❑HEAVY DATE OF LAST MENSTRUAL PERIOD__________________________. CERTAINTY OF LMP ❑SURE ❑UNSURE.

METHOD OF BIRTH CONTROL: ❑CONDOMS ❑PILLS: NAME_________________________ ❑IUD ❑DEPOPROVERA
❑NUVA RING ❑IMPLANON ❑DIAPHRAGM ❑TUBES TIED ❑ORTHO EVRA PATCH

BREAKTHROUGH BLEEDING ❑YES ❑NO. DO YOU PASS CLOTS? ❑YES ❑NO.

MOOD SWINGS AROUND TIME OF PERIOD? ❑YES ❑NO. PREVIOUS DIAGNOSIS OF ❑POLYCYSTIC OVARIES ❑ENDOMETRIOSIS

IF YOU ARE POST-MENOPAUSAL:

AGE AT MENOPAUSE___________YRS.

HORMONE REPLACEMENT THERAPY EVER? ❑NO ❑YES TYPE____________________________________ #YRS._______. HOT FLASHES? ❑YES ❑NO.

ANY PREGNANCY HISTORY INCLUDING TUBAL & MISCARRIAGE

TOTAL PREGNANCIES_______ FULL-TERM_______ PRE-MATURE_______ # MISCARRIAGES_______ #ABORTIONS_______

TUBAL PREGNACY_______ # MULTIPLE PREGNANCIES (TWINS)_______ #C-SECTIONS_______ # LIVING CHILDREN_______

PAP HISTORY

DATE OF LAST PAP:____________ NORMAL ❑YES ❑NO ANY ABNORMAL PAPS? ❑YES ❑NO DATE AND TREATMENT_____________________________

WHERE WAS PAP DONE:____

FAMILY HISTORY:
(Mom, Dad, Gr. Parents, Brother, Sister, Aunts, Uncles)

	NO	YES	IF YES, RELATIONSHIP TO YOU AND CANCER TYPE
CANCER	❑	❑	
HIGH BLOOD PRESSURE	❑	❑	
HIGH CHOLESTEROL	❑	❑	
LUNG DISEASE	❑	❑	
DIABETES	❑	❑	
THYROID PROBLEMS	❑	❑	
SEIZURE DISORDER	❑	❑	
DEPRESSION, ANXIETY OR RELATED DISORDER	❑	❑	
KIDNEY DISEASE	❑	❑	
BONE, MUSCLE OR JOINT DISEASE	❑	❑	
HEART PROBLEMS	❑	❑	

SOCIAL HISTORY:

JOB TITLE: ________________________________ MARITAL STATUS: ❑SINGLE ❑MARRIED ❑DIVORCED ❑WIDOWED ❑SEPARATED ❑ENGAGED

EXERCISE: ❑NO ❑YES ❑ACTIVE, BUT NO FORMAL EXERCISE ❑HEAVY, 4 OR MORE TIMES PER WEEK ❑MODERATE, 1-3 TIMES PER WEEK
❑MINIMAL ❑SEDENTARY

TOBACCO USE: ❑NO ❑YES TYPE____________________#PER DAY_______________FOR_________YEARS. QUIT? ❑YES WHEN_______________

ALCOHOL USE: ❑NO ❑YES TYPE____________________#PER DAY_______________FOR_________YEARS. QUIT? ❑YES WHEN_______________

ILLEGAL SUBSTANCE USE: ❑NO ❑YES TYPE__________________FREQUENCY____________FOR_________YEARS. QUIT? ❑YES WHEN_______________

CAFFEINE USE: (Tea, Coffee, Soda) ❑NO ❑YES TYPE____________________#PER DAY_______________FOR_________YEARS.

EMOTIONAL OR PHYSICAL ABUSE AT HOME ❑NO ❑YES____

HAVE YOU EVER HAD SEXUALLY TRANSMITTED DISEASE?

	NO	YES	DATE AND TREATMENT
CHLAMYDIA	❑	❑	
GONORRHEA	❑	❑	
GENITAL WARTS	❑	❑	
HIV	❑	❑	
SYPHILIS	❑	❑	
TRICHOMONIASIS	❑	❑	

ARE YOU HERE FOR ❑YEARLY EXAM ❑PROBLEM

IS THERE ANYTHING YOU WOULD LIKE YOUR PRACTITIONER TO DISCUSS WITH YOU OR PAY SPECIAL ATTENTION TO?

____

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____

____ ______________________

SIGNATURE **DATE**