

SOUTHWEST WOMEN'S HEALTH ASSOCIATES

NAME _____ AGE _____ DATE _____

OCCUPATION/EDUCATION _____

PRIMARY CARE PHYSICIAN _____

ALLERGIES (i.e. drugs, pollens, foods)

Name of Allergy	Type of Reaction
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_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS/VITAMINS/SUPPLEMENTS

IMMUNIZATIONS (list date of **most recent** vaccine if known):

Tetanus _____ Pneumonia _____ Hepatitis B _____

SURGERIES, ILLNESSES, ACCIDENTS (list type/dates)

ALTERNATIVE HEALTH CARE: (i.e. naturopathic, chiropractic)

LIFESTYLE BEHAVIORS:

Do you currently smoke? Yes No Amount _____

Did you smoke in the past? Yes No # of years _____

Date you quit _____

Caffeine type/use per day _____

Alcohol type/use per week _____

How often do you exercise? _____

What type of exercise? _____

PREGNANCY HISTORY: (list number of the following)

Pregnancies _____ Live births _____ Still living _____

C-Sections _____ Miscarriages _____ Abortions _____

Stillbirths _____ Tubal pregnancies _____

Plans for future pregnancies? Yes No Undecided

PERSONAL GYN HISTORY:

Yes	No	
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Ovary Problems

Uterus Problems

Genital Herpes

Genital Warts

Chlamydia or Gonorrhea

Pain or other problems with sex

Irregular bleeding or problems with periods

Breast disease/problems

Have you ever had a mammogram?

Date of most recent: _____

Date of most recent Pap Smear: _____

History of abnormal Pap Smears: _____

FAMILY MEDICAL HISTORY: (Check if grandparents, parents, children or siblings have had any of the following)

List relative(s)
with illness

Yes	No	
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Breast cancer

Ovarian cancer

Prostate cancer

Heart attack under age 50

High blood pressure

High cholesterol

Colon cancer

Stomach cancer

Melanoma

Osteoporosis

Diabetes

Thyroid Disease

Mental health problems

Alcoholism

PERSONAL MEDICAL HISTORY: (check if you have had any of the following)

Yes	No	
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Migraine Headaches

Numbness/visual disturbance/dizziness

Seizures/epilepsy

Skin problems

Chronic breathing problems or asthma

High cholesterol

High blood pressure

Heart disease or problems

Blood clots or stroke

Intestinal or stomach problems

Gall bladder disease

Liver Disease

Bone/joint or muscle problems

Kidney or bladder problems

Anemia or blood disorder

Thyroid disease or problems

Diabetes (including pregnancy related)

Cancer

Mental health problems/depression

Other medical problems or additional information:

Provider Signature _____ Date _____