Women's Pelvic Care

Patient Name: ______________________

Date of Birth: ______________________

PATIENT HISTORY/SELF ASSESSMENT

Date of visit: ____________________ Primary Care Provider: ____________________________

Your age: ____________________ Reason for visit: ____________________________

ALLERGIES and Adverse Drug Reactions (Describe reaction if known): ☐ None

MEDICATIONS currently taking: ☐ None ____

SURGERIES you have had: ____

FAMILY HEALTH HISTORY - Has anyone in your family had any of the following?

☐ Breast Cancer ☐ Diabetes ☐ Heart disease ☐ Stroke
☐ Ovarian Cancer ☐ Colon Cancer ☐ High cholesterol

HEALTH HISTORY - do you currently have or have you ever had any of the following?

☐ Blood clots ☐ Cancer ☐ Abnormal pap smear ☐ Migraine headaches
☐ High blood pressure ☐ Diabetes ☐ Breast problems ☐ Severe depression
☐ Pelvic inflammatory disease ☐ Heart disease ☐ Thyroid Problem
☐ Stroke or heart attack ☐ Other____

GYNECOLOGICAL HISTORY - Age at first menstrual period: ______ **Menopausal:** ☐ No ☐ Yes - how long? _______

First day of last period: ____________ **Frequency of periods:** __________

Number of pregnancies: __________ Miscarriages / Abortions: __________ Ages of children: __________

Method of contraception: __________________________________ How long? ___________________________________

Problems with this method? ☐ No ☐ Yes - describe ____

Have you ever had Gonorrhea, Chlamydia, or any other sexually transmitted diseases? ☐ No ☐ Yes

Last Pap Smear - approximate date: _____________ **Results**: ☐ Normal ☐ Abnormal

Have you ever had a M**ammogram**? ☐ No ☐ Yes - approximate date: **Results:** ☐ Normal ☐ Abnormal

SOCIAL HISTORY **Relationship Status:** ☐ Single ☐ Spouse/partner ☐ Widowed

Sexual Activity: ☐ Not currently sexually active ☐ Sexually active with: ☐ Male ☐ Female ☐ Both

Occupation: ____

Do you drink alcohol? ☐ No ☐ Yes - Type: __________________________ Frequency: ____________________________

Do you smoke? ☐ No ☐ Yes # per day: ______ Years: _____ ☐ Quit-date: __________

Do you use recreational drugs? ☐ No ☐ Yes Type: ________________________ Frequency: _______________________

Do you have any concerns or questions that you would like to discuss at this visit? ☐ No ☐ Yes - Describe:_______________

The information provided above is accurate to the best of my knowledge.

Patient signature: ____