WOMEN'S PHYSICIANS & SURGEONS **ANNUAL PATIENT INFORMATION SHEET**

an Axia Women's Health Care Center

Date ______________________ Name ____DOB___/___/___ Age _______

Home Phone # _____________________Work Phone # _____________________ Cell Phone # ________________________

Address ____City ____________________ State ____ Zip _______

Patient Employer _______________________________________ Patient Occupation _______________________________

First Name of Spouse/Partner _______________________ Marital Status: Married □ Divorced □ Separated □ Single □

If we need to notify you for results: Can we leave a message on your Answering Machine □ Yes □ No Widowed □

When we call your home, who can we leave a message with?____

Name, Phone # & Fax # of your Primary Physician:____

Name & Phone # of your Pharmacy: ____

Can we email you? Y N Email Address: ____

MENSTRUAL HISTORY

Age at first menstrual period_________ Date of last menstrual period___/___/___ How many days do you bleed? ____

How many days from the start of one period to the start of the next period? _____

Was the flow □ Light □ Normal □ Heavy Do you bleed between periods? □ Yes □ No

Do you have Menstrual Cramps: □ Yes □ No □ Mild □ Medium □ Severe

Do you take medication for cramps?_________ What is the medication? ____

Contraception: □ Pills □ Condoms □ Tubal □ Vasectomy □ Diaphragm □ DepoProvera □ IUD □ Other _________

Do you have children? □ Yes □ No If yes, do you plan on having more? □ Yes □ No________________________

Do you have Painful Sex: □ Yes □ No If Yes, is it □ Mild □ Medium □ Severe □ Not sexually active

Bleeding after Menopause: □ Yes □ No Leakage of Urine: □ Yes □ No If Yes: □ < once/week □ Weekly □ Daily

GENERAL HISTORY

Last Mammography	Date ___/___/___	□ Normal	□ Abnormal	Treatment:
Last Bone Density	Date ___/___/___	□ Normal	□ Abnormal	Treatment:
Last Colonoscopy	Date ___/___/___	□ Normal	□ Abnormal	Treatment:
Do you Smoke?	□ Current □ Past	□ Never	Amount:	
Do you Exercise?	□ Yes □ No	Amount:		
Do you Abuse Drugs?	□ Yes □ No	Amount:		
Do you Drink Alcohol?	□ Yes □ No	Amount:		

FAMILY HISTORY

Breast Cancer	□ Yes □ No	Who:
Ovarian Cancer	□ Yes □ No	Who:
Uterine Cancer	□ Yes □ No	Who:
Cervical Cancer	□ Yes □ No	Who:
Colon Cancer	□ Yes □ No	Who:
Thyroid Disease	□ Yes □ No	Who:
Osteoporosis	□ Yes □ No	Who:

Please list all medications you take: ____

Please list all vitamins you take: ____

Please list all medications you are allergic to: ____

Are you allergic to Latex?_______ **Patient Signature** ____