Women's Physicians & Surgeons

an Axia Womens Health Care Center

Patient Information Sheet

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 □ Widow □

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

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 e-mail you? Y N Email Address: ____

MEDICAL HISTORY

	YES	NO		YES	NO		YES	NO		YES	NO
Migraines			Anemia			Chlamydia			Heart Murmur		
Epilepsy			Blood Clots, DVT, PE			Endometriosis			Mitral Valve Prolapse		
Asthma			Blood Transfusions			Gonorrhea			Osteoporosis		
Pneumonia			Diabetes			Herpes			Cancer		
Benign Breast Disease			Hepatitis			Venereal Warts			Type		
Rheumatic Fever			High Blood Pressure						Intestinal Disorders		
Kidney Infection			High Cholesterol						Colitis / IBS / GERD		
Gallbladder Disorders			Thyroid								

SURGERIES (i.e. D&C, Appendix, etc.)

Date	Operation/Procedure	Date	Operation/Procedure

PREGNANCIES

Year	Weight and Sex of Baby	Vaginal or C-Section	Hrs in Labor	Weight Gain	Complications During Pregnancy or Delivery	Delivered Early, Late, On Time

Do you have problems concerning or carrying pregnancies? □ Yes □ No What are your concerns? ___________________

____

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?______

Name ______________________________________ Patient Information Sheet

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:
Last Pap Smear	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:
High Blood Pressure	□ Yes	□ No	Who:
Osteoporosis	□ Yes	□ No	Who:

Do you have a Living Will? □ Yes □ No How did you hear about our practice?________________________________

____

Signature of Patient