

Western Carolina Women's Specialty Center Patient Intake History

Name: _____ Age: _____ Date of Birth: ___/___/___ Visit Date: ___/___/2009

Reason for today's visit: _____

Referring MD: _____ Primary MD: _____

Medications: Outside our practice: _____

From our practice: _____

Calcium Supplement: none _____ mg/day Vitamin D Supplement: none _____ IU/day Multivitamin:

Drug Allergies: none _____

Medical Conditions: none Abnormal Pap smear: Year-_____ Treatment-_____

- | | | | | |
|------------------------------------|---|--|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart attack: Year- _____ | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Stomach ulcer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Hepatitis/liver disease | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Stroke: Year- _____ |
| <input type="checkbox"/> Bipolar | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Thyroid |

Blood Clot: Year-_____ Treatment- _____

Breast Problem: _____

Cancer - Breast Cervix Colon Ovary Uterus other: _____

Treatment- _____

Other medical problems: _____

Past Surgery: no major surgery

hysterectomy Year- _____ - vaginal abdominal one ovary both ovaries- removed

bladder control surgery- Year- _____ vaginal abdominal

Other surgeries: breast- _____ gall bladder tonsils hip replacement knee replacement

Gynecologic History: Last menstrual period: _____

Age at 1st menstrual cycle: _____

- My cycles are regular every _____ days
 My cycles are irregular, every _____ to _____ days
 My cycles stopped in _____ No hormone therapy

Obstetric History: Number of pregnancies _____
 Number of vaginal deliveries ____ C-sections ____
 Weight of largest child _____ lb _____ oz
 Tear into rectum

Hormones since: _____ Used hormones for ____ years

Contraception: none Birth control pills tubal vasectomy other

Family History: Please note which family member(s) & age at onset of the condition

- | | |
|--|--|
| <input type="checkbox"/> Cancer: Breast- _____ | <input type="checkbox"/> Cancer: Cervix- _____ |
| <input type="checkbox"/> Cancer: Colon- _____ | <input type="checkbox"/> Cancer: Ovary- _____ |
| <input type="checkbox"/> Cancer: Uterus- _____ | <input type="checkbox"/> Cancer: other - _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart attack- _____ |
| <input type="checkbox"/> Osteoporosis- _____ | <input type="checkbox"/> Stroke- _____ |

Social History:

Marital status: single divorced married widowed partner
 Lives with: self spouse children significant other friend assisted care
 Occupation: _____ Do not work outside the home Retired from: _____
 Education: elementary school high school college postgraduate- _____
 Exercise: none rare regular (2-3 times/week several times/week)
 Type of exercise: walk other- _____

Tobacco use: none former- quit _____ y ago _____ pack/d for _____ y

Alcohol use: none _____ drinks per week Recreational Drug Use: _____ none

Most Recent Screening Tests:	Test	Year	Normal	Abnormal	Test	Year	Normal	Abnormal
	Bone Density		<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol		<input type="checkbox"/>	<input type="checkbox"/>
Colonoscopy		<input type="checkbox"/>	<input type="checkbox"/>	Mammogram		<input type="checkbox"/>	<input type="checkbox"/>	
Pap		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	

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Please check any of the following symptoms that you are having:

Constitutional: fatigue fever loss of appetite
 unplanned weight loss unplanned weight gain

Eyes: unexplained visual changes

Breast: lumps pain skin changes
 nipple discharge

Cardiovascular: chest pain palpitations

Respiratory: shortness of breath cough

Gastrointestinal: nausea vomiting constipation
 early fullness abdominal pain blood in stools
 black or tarry stools narrow stools leakage of stool

Urinary: urinary urgency urinary frequency pain with urination
 leakage of urine incomplete emptying void > 2 times overnight

Gynecologic irregular bleeding heavy periods painful periods
 vaginal discharge painful intercourse vaginal dryness
 postmenopausal bleeding vaginal bulge

Skin: changes in mole new worrisome changes

Neurologic: muscular weakness

Musculoskeletal: joint pain low back pain

Endocrine: decreased libido excess hair growth night sweats
 hot flashes

Psychiatric: anxiety depression difficulty sleeping

Hematology: lymph node enlargement