General Female Medical & Menstrual History & Physical

Patient Full Name: ____ Date: ____/____/_______

Your appointment date & time is: _____/______/_________@________am pm. Bring any medical records such as scans, labs, X-rays etc.

Patient Information **Bring Insurance Information & Photo ID (driver's license) to Office Visit**

Name:____

Address:_____________________________________City:______________State:_________Zip____________

Phone (______)__________________ Work Phone (_____) _______________ Cell Phone (______)_______________

The best time to contact me is:___________________ ☐ morning ☐ afternoon ☐ evening at ☐ Home ☐ Work ☐ Cell.

Date of Birth: _____/_____/_____ Social Security Number:_________-______-___________

If Student, Name of School______________________________ City/State__________________________ ☐ FT ☐ PT

Spouse or Parent's Name:____________________________ Employer__________________ Work Phone____________

Person to contact in case of emergency__________________________________ Phone_________________________

Provide **your email** & you can access your health records online securely:_______________________________________

Referring Doctor(first&last name):_____________________________ Phone#:____-____-________Fax#:____-____-________

☐ Our Website ☐ Friend ☐ Facebook ☐ Google ☐ Bing ☐ Radio ☐ Billboard ☐ TV
☐ Walk-in ☐ Phone book ☐ Newspaper / Print ☐ Digital Advertising ☐ Different Website _______________

_______________**Reason for visit:** Please include when condition (s) started, is it better or worse now? What tests/ treatments have been done? Any Medications started? If you have pain, please describe below and include Location - Timing (constant, occasional, episodic, minuets/hours, a.m./p.m.) ____

____

____

____

Number of Pregnancies: _____ Number of Live Births:_____ Number of miscarriages/abortions: ______

Hysterectomy: yes no Removal of any ovary: yes no Reason & Date:______________________________

Last Menstrual Cycle: _________, Regular Cycles: yes no, Bleeding pattern/length of cycles: __________________

Do you have Premenstrual Syndrome (PMS)? yes no, If yes, please list symptoms ____________________________

Any history of chemotherapy or radiotherapy? yes no____

Do you do Self Breast Exams? yes no, Any Abnormal Findings: ____

Date of Last Mammogram: ________, Any mammogram abnormalities? Yes No

Date of Last Pap Smear: ___________. Ever had an abnormal pap smear? Yes No

Have you ever used oral contraceptives? Yes No, When & Any Problems: ____________________________________

Menopausal Symptoms: Please check all that apply: ___ Personal History of Breast, Uterine, or Ovarian Cancer

___ Fibrocystic Breast ___ Depression ___ Breast Tenderness ___ Memory Loss
___ Weight Gain ___ Night Sweats ___ Insomnia ___ Bladder Symptoms
___ Heavy Menses ___ Vaginal Dryness ___ Cramps ___ Arthritis
___ Hot Flashes / Flushes ___ Headaches ___ Fluid Retention ___ Hair Loss
___ Dry Skin/Hair ___ Irritability ___ Vaginal Spotting ___ Decreased Sex Drive
___ Anxiety ___ Mood Swings ___ Fatigue ___ Climax Difficulty
___ Painful intercourse ___ Breast tenderness ___ Irregular Menses (periods) ___ Osteoporosis
___ Any Stress Urinary Incontinence (leak urine when coughs, sneezes, etc.)

Hypothyroidism: Subclinical or Symptomatic: Do you have these symptoms consistent with low thyroid:
___ weakness, ___ lack of energy, ___ depression, ___ weight gain.

Low Vitamin D Risk Factors: ___ inadequate sunlight, ___ breast feeding, ___ calcium deficiency, ___ phosphate deficiency, ___ dark skinned, ___ Use of frequent: __ antacids __ loop diuretics __corticosteroids __ anticonvulsants, __ intestinal malabsorption, __liver disease (affects conversion of D2 to D3, __renal disease.

Past Surgical History (please check all that apply & approximate date of surgery)

__Aortic Aneurysm
__Appendectomy
__Breast Reduction
__Breast Lift
__Breast implants
__Breast Fat Transfer
__Carotid Surgery, R or L
__Cataract/Eye
__Carpal Tunnel
__Colonoscopy
__Colon surgery
__C-Section
__D & C
__Endometrial Ablation
__Facelift
__Foot Surgery
__Gallbladder
__Gastroscopy
__Gastric Bypass
__Gastric Sleeve
__Heart Bypass
__Heart Angioplasty/Stents
__Hernia
__Hip Surgery
__Hysterectomy
__Knee Surgery
__Laparoscopy, __Liposuction
__Lumbar (Disc) Surgery
__Lung Surgery
__Neck surgery
__Pacemaker
__Prostate Surgery
__Shoulder Surgery
__Splenectomy (↑DVT, PE)
__Stomach Surgery
__Thyroid Surgery
__Tonsillectomy
__Tummy Tuck
__Ovarian Tubal Ligation
__Vascular Surgery
__Vein Surgery, R or L
__Uterine Ablation
__Urinary Bladder Surgery

Any Other Surgeries ____

Any prior Transfusions? Y N. Any problems with anesthesia? Y N. Explain ______________________________

Any history of blood clots or pulmonary embolus? Y N Any history of Liver disease? Yes No

Past Medical History (please **check** all that apply) (please circle **Active** for all that are currently being treated)

__Abnormal Healing` Active
__Acid Reflux (GERD) Active
__Alcohol abuse history Active
__Anemia Active
__Anorexia Active
__Arthritis Active
__Asthma Active
__Bladder Infections Active
__Blood Disorder Active
__Bronchitis Active
__Cancer Active
__Chest pain (angina) Active
__Cold sores Active
__Dentures Active
__Depression Active
__Diabetes Active
__Drug abuse history Active
__Fibromyalgia Active
__Gout Active
__Heart Attack Active
__Hepatitis Active
__Hernia Active
__High Blood Pressure Active
__HIV Active
__Insomnia Active
__Irregular Heart Active
__Kidney disease Active
__Liver Disease Active
__Lymphedema Active
__Malignant Hyperthermia
__Motion sickness Active
__Nausea/Vomiting Active
__Neuropathy Active
__Oxygen use Active
__Palpitations Active
__Pancreatitis Active
__PCOS-Polycystic Ovarian Active
__Scarring/Keloids Active
__Seizures Active
__Shortness of breath Active
__Sinus problems Active
__Sleep Apnea Active
__Stroke/TIA Active
__Thyroid disease Active
__TMJ syndrome Active
__Tuberculosis Active
__Ulcers, stomach Active
__Varicose veins Active
__Vision Problems Active
Other________________________
Other________________________

Review of Systems (Please circle all that apply)

- **Constitutional:** Fever, chills, night sweats, trouble swallowing, weight loss/gain ______lbs.. Insomnia.
- **Skin:** Ulcers, Rash, Itching, Cellulitis, Melanoma, Skin Cancer, Eczema, Psoriasis
- **Eyes:** Temporary loss of vision in one eye, Blurred Vision, Cataracts, Glasses, Macular Degeneration.
- **ENT:** Dentures, Ear Problems, Hearing Aid, Nose Bleeds, Congestion, Swallowing Problems
- **Cardiac:** Chest pain with exertion, Palpitations, Leg swelling, Ankle swelling, Leg pain, leg pain at rest, leg pain with activity, last stress test ____________, Echocardiogram ______________
- **Respiratory:** Short of breath (SOB), Wheezing, SOB when lying flat, Cough, change in voice/hoarseness.
- **GI:** Nausea, Vomiting, Diarrhea (stool per day_____), Constipation (On average, stool every day _____), Abdominal pain, Blood in stool, black stool , Heartburn, acid Reflux, Colon Polyps, generally eat high or low fiber diet, high or low fat diet.
- **GU:** Burning when urinate, frequency, urgency, Prostate problems, Kidney disease, Genital Warts, Herpes
- **Musculoskeletal:** Pain legs/calf with walking, Sciatica, back pain, back disc disease, joint pain, neck pain.

- **Neurologic:** Dizzy, lightheaded, weak or numb one side- arm/leg/face, headache, passing out.
- **Psych:** Depression, Anxiety, Psychosis, Dementia, Bipolar
- **Endocrine:** Excessive thirst or urination, Thyroid disease
- **Heme/Immune:** HIV/AIDS, Hepatitis A, B, C, easy bruising, clotting disorder.

Medications: List all medications, dosages, frequency, and include all natural supplements: ____________________

____

____

Any Diet Pills: Yes No
Latex Allergy: Yes No
Xylocaine "caine" any local anesthetic Allergy: Yes No
Drug Allergies & Type of Reaction: ____

____

Environmental Allergies: ____

Social History: Check all that apply: Alcohol _____. How much _________________________________ Tobacco-Smoke _____ Dip _____ Chew ____ How much & how long? _______________________ If you quit, when? _________
Live Alone ______ Employed ______ Disabled _____ Retired _____ Student _____ Homemaker _____ Married ____
Divorced ____ Widowed ____ Never Married _____

Family History: Please specify which family member (s):

□ Hypertensions ______________________	□ Heart Problems ______________________
□ Aneurysm ______________________	□ Varicose Veins ______________________
□ Uterine Cancer ______________________	□ Heart Disease ______________________
□ Ovarian Cancer ______________________	□ Osteoporosis ______________________
□ Breast Cancer ______________________	□ Diabetes ______________________
□ Prostate Cancer ______________________	□ Stroke ______________________
□ Clotting disorder ______________________	□ Other: ______________________

Other Information by Patient ____

____

____

____

____

____

____

____

Patient Signature: ____________________________________ Date: ____/____/________