NEW RIVER WOMEN'S Health

Patient Name: _____ DOB:_____

Single / Married / Widowed / Divorced / Domestic Partner

Spouse / Partners Name: _____

Employment / Profession: _____

Primary Care Doctor or Nurse Practitioner: _____

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Date of last menstrual period: _____

Medication Allergies: _____

List of
medications:_____

_____

_____

_____

_____

Tobacco Use: YES / NO If YES, how long and how much: _____

Alcohol Use: YES / NO If yes, how often _____

Illegal Drug Use: Yes / No If yes, what and how often _____

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Date of last Women's Health Exam / Pap Smear: _____

Do you have a history of an abnormal pap? YES / NO If so when? _____

Date of last mammogram: _____

Date of last colonoscopy: _____

Date of last bone density: _____

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Pregnancy History: please check all that apply and how many of each:

Pregnancies _____ Vaginal Births _____

Cesarean Sections _____ Miscarriages _____

Fetal Demise _____ Elective Abortion _____

NEW RIVER WOMEN'S Health

Past Medical History: please check all that apply

Hypertension _____ Diabetes _____

Heart Disease _____ Stroke _____

High Cholesterol _____ Migraines _____

Thyroid Disorder _____ Seasonal Allergies _____

Asthma _____ Seizure Disorder _____

Osteopenia _____ Osteoporosis _____

Depression _____ Anxiety _____

Chronic Kidney Disease _____ Anemia _____

Gastrointestinal Disorders _____

Cancer: _____

Other/Details:_____

_____

_____

****

Past Surgical History: please check all that apply

Procedure	Date If Known	Procedure	Date If Known
Appendix _____		Tonsillectomy _____	
Gall Bladder _____		D&C _____	
Hysterectomy _____		Endometrial Ablation _____	
C-Section _____		Hernia _____	
Incontinence Procedure _____		Right or Left Ovary removal _____	

Sterilization (Tubal / Essure / Partner Vasectomy) _____

Other Surgeries:

_____

_____

NEW RIVER WOMEN'S Health

Family History: Please check all that apply

Diabetes _____

Heart disease _____

Stroke _____

Asthma _____

High Blood Pressure _____

High Cholesterol _____

Mental Health Disorders _____

Breast cancer _____

Ovarian cancer _____

Uterine cancer _____

Colon cancer _____

Melanoma _____

Osteoporosis _____

Other/Details:_____

_____

_____

_____