Contemporary Women's Care

Name: _____ **Date:** _____

Date of Birth: _____ **Phone Number:** _____

Mailing Address: _____

Reason for today's visit? _____

When was your last period _____ Current Contraceptive Method: _____

Current Medications (including vitamins, herbs, supplements): _____

_____

Allergies: _____

Please list any new problems, diagnoses, or changes since your last annual exam.

Medical history: _____

Surgical history: _____

Family history: _____

Marital status: _____ Persons in home: _____ Occupation: _____

Exercise Type: _____ Times per week: _____

Diet: Are you following a special diet? _____

Fat: High _____ Medium _____ Low _____

Dairy: _____ Servings per day (8 oz. milk, 6 oz. yogurt, 1 oz. cheese)

Tobacco: _____ yes _____ no If yes, how many packs per day? _____

Alcohol: How many drinks per day _____ week _____ month _____

Recreational drugs: _____ yes _____ no Please list: _____

Do you: Wear seat belts? _____ Yes _____ No

Have smoke detectors? _____ Yes _____ No

Have carbon monoxide detectors? _____ Yes _____ No

Perform a monthly self-breast exam? _____ Yes _____ No

For Nurses to fill in:

HT _____ WT _____ BP _____