Women's Health Care Center of Houston

Name ___________________________________ Date of Birth _____________________ Date ______________________ .

Age __________ Primary Care provider _____________________________ Primary Language ______________________ .

Reason for Visit: _____Well Woman Exam **OR**_____ Problem/Symptoms:_______________________________________ .

Who referred you to us?____ _______________________________

Well Woman Update: (Please provide dates where applicable)

Last Pap smear _______________ (month/year)

Last HPV testing _______________ (month/year)

Last mammogram_____________________ (year)

Last bone density exam ________________ (year)

Last colonoscopy _____________________ (year)

Last tetanus shot _____________________ (year)

HPV/Gardasil Vaccine series completed? _____ YES_____NO

Have you had the Hepatitis B series? ______ YES _____NO

Colposcopy ____Yes _____No ______Year

Any abnormal Pap smears? ______YES ______ NO

Cervical Dysplasia (precancerous cells of the cervix? ______YES______NO

If yes, any treatment? Dates:

Cryo freezing ________________________________.

Laser ________________________________.

LEEP ________________________________

Cone Biopsy ________________________________.

Medical History: Do you now have or have you ever had:

- ☐ Asthma
- ☐ Autoimmune disorder _________________ .
- ☐ Bleeding Disorder
- ☐ Blood Disorder
- ☐ Blood Transfusion
- ☐ Bone/Joint Disease
- ☐ Cancer (type)
- ☐ _________________
- ☐ Chlamydia
- ☐ Deep Vein Thrombosis
- ☐ Anxiety disorder
- ☐ Other:_______________
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Elevated cholesterol
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Glaucoma
- ☐ GERD/Reflux
- ☐ G.I. disorder ________ .
- ☐ Gestational Diabetes
- ☐ Gonorrhea
- ☐ Heart disease
- ☐ PCOS
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes
- ☐ Infertility
- ☐ Irritable Bowel
- ☐ HIV
- ☐ HPV/genital warts
- ☐ High Blood Pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney disease
- ☐ Sickle cell trait
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Migraines
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pelvic infection
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Syphilis
- ☐ Trauma
- ☐ Tuberculosis
- ☐ Psychiatric disorder _________________.

Surgical History: Please list ALL surgical Procedures and hospitalizations, including year:

____.

____.

____.

____.

____.

____.

Anesthesia Complications: ☐ difficulty waking up ☐ Malignant hyperthermia

Medications & dose including birth control, vitamins, supplements:		
Allergies: seasonal	latex	iodine
Drug allergies:	**Medication**	**Reaction**

Family History: Include the age of onset and type of cancer.

ILLNESS	Mother	Father	Brother	Sister	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Other relative
Cancer (type)									
Diabetes (type)									
Hypertension									
Heart Disease									
Osteoporosis									
DVT									
BRAC positive									

Please Complete Other Side

Reproductive History: Menstrual Cycle

Age at first period? _________ If menopausal, age of menopause: ______

How often do you get your menstrual cycle? Every ________________________ days, lasting __________ days.
Last Menstrual Period: ______________________________
Are your periods painful? ________ No ________ Yes
Are you sexually active? ________Never _______Yes _______Not currently
Do you have pain with intercourse? _______No _______Yes

Method of contraception:

	Not Needed		Vasectomy		Natural Family Planning		Nexplanon		Tubal Ligation
	None		Condoms		NuvaRing		Mirena IUD		Essure
	Pill		Patch		Depo Provera		ParaGuard IUD		Withdrawal
	Skyla IUD		Kyleena IUD		Liletta IUD				

Obstetrical History:
Please list all pregnancies, including miscarriages, abortions, and ectopic pregnancies. Please include full birthdate.

Type: vaginal, C-section **Anesthesia:** epidural, local, general, spinal
Complications: EXAMPLES: preterm labor, diabetes, bleeding, high blood pressure, postpartum depression.

Past Pregnancies:

Birthdate	Weeks	Length of Labor	Baby's Weight	Sex	Type of Delivery	Anesthesia	Complications	Location

Social History:
Occupation: ____

Are you _____Married ____Single ____Engaged ____Significant other ____Divorced ____Widowed ____Same Sex
Significant other's name: ____

Tobacco Use: ____ Never ____ Current_____ # of Cigarettes per day ____ Former, Quit at age_______.

Any alcohol use? YES NO *If yes, the average number of drinks per week.____________.
Do you use street drugs? YES NO *If yes, the type used and last use.______________________________.

How many times and how long per week do you exercise? (circle) 1X 2X 3X 4X 5X+ None
Per session: 20 min 30 min 45 min 60+ min
Do you eat a healthy diet? (circle) Daily Some No

Any history of violence, rape or abuse in your current household or in your past ____ NO ____ YES______________

Do you have any cultural or religious considerations that need special attention? ____NO ____YES________________

*****Subject to the needs of your health, a scheduled appointment may be changed**
By the provider to a different type of appointment. _________ **(Please Initial)**

Patient signature____ **Date:** ______________________________.
****I verify the above information is true and accurate****

PLEASE COMPLETE BOTH SIDES