TWO CONVENIENT LOCATIONS:
168 North Brent Street, Suite 407
Ventura, CA 93003
(Across from Community Memorial Hospital)
110 West Harvard Boulevard, Suite D
Santa Paula, CA 93060
(805) 648-2717 • www.WomensHealthMedGroup.com

NAME____________________________DOB_____________ Age_____________ Date _____________

Reason(s) for visit ____

____

ALLERGIES ____

Last normal menstrual period____________________ Age at first menstrual period ______________
Length of periods ______________ Number of days between periods__________________________
Do you have clots? _ yes _ no Do you have painful periods? _ yes _ no
Do you bleed between cycles? _ yes _ no Do you have painful intercourse? _ yes _ no
Last PAP test__________________________ Any abnormal results? _ yes _ no
Last Mammogram______________________ Any abnormal results? _ yes _ no
Last Colonoscopy ____
Last bone density if applicable____
Method of contraception: _ sterilization (partner, self) _ pills _ Depo-Provera _ diaphragm
_ IUD _ foam/gel _ condoms _ natural family planning
_ others ____
Do you leak urine? _ no _ all the time _ with lifting/coughing _ only occasionally
Do you wear incontinence pads often? _ yes _ no
Do you have difficulty stopping or starting your stream? _ yes _ no

OB HISTORY Pregnancies______ Births______ Miscarriages______ Cesareans______ Abortions______ None______

MEDICAL HISTORY

_ Asthma
_ Anemia
_ Diabetes
_ High blood pressure
_ High cholesterol
_ Heart attack
_ Stroke
_ Mitral valve prolapse
_ Arthritis
_ Hepatitis
_ Deep vein thrombosis
_ Fibromyalgia
_ Frequent bladder inf.
_ Depression/Anxiety
_ Breast Cancer
_ Endometriosis
_ Fibrocystic breasts
_ Thyroid Disease
_ Bleeding disorder
_ Ulcerative colitis
_ Blood transfusion
_ Fibroids
_ Condyloma/warts
_ Ovarian Cysts
_ Gonorrhea/Chlamydia
_ Genital Herpes
_ Ulcer/GERD
_ HIV/AIDs
_ Others ____

SURGICAL HISTORY

_ Cone biopsy
_ D&C
_ Cryotherapy
_ Laparoscopy
_ Hysterectomy
_ Bladder procedure
_ Ovarian cystectomy
_ Breast Biopsy
_ Breast implants
_ Appendectomy
_ Gallbladder surgery
_ Tonsillectomy
_ Knee surgery
_ Back surgery
_ Hip surgery
_ Others ____

MEDICATIONS (name, dosage and frequency, including herbs)

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

SOCIAL HISTORY NAME ______________________________

Occupation ______________________ How many hours do you work/week? __________

Have you ever been sexually active? _ yes _ no

Are you currently sexually active? _ yes _ no

Do you smoke? _ yes _ no. If yes, packs per day? __________ How many years? __________

Are you interested in smoking cessation? _ not yet _ maybe next year

How much alcohol do you drink? ______________________________

How much coffee/tea do you drink? ______________________________

Any recreational drugs? _ yes _ no If yes, what kind ______________________________

How much do you exercise? ______________________________

FAMILY HISTORY

Mother (age, health status) ______________________ Father ______________________

Sisters ______________________ Brothers ______________________

_ breast cancer (mother, aunt, sister) _ ovarian ca _ uterine ca _ cervical ca _ colon ca

_ diabetes _ heart disease _ high cholesterol _ heart attack _ hypertension _ osteoporosis

REVIEW OF SYSTEMS

General well-being _ good _ weight loss _ weight gain _ fever _ fatigue

Eyes/ears/nose/throat _ good _ sinusitis _ headache _ hearing loss

_ ulcers _ cataracts _ glaucoma _ visual blurring

Cardiovascular _ good _ chest pain _ difficulty breathing _ swelling

_ irregular heart beat

Respiratory _ good _ wheezing _ shortness of breath _ cough

Breast _ good _ pain _ new lump _ discharge

Gastrointestinal _ good _ diarrhea _ bloody stool _ gas _ constipation

_ nausea/vomiting/indigestion _ soiling of stool _ painful bowel movement

Musculoskeletal _ good _ muscle weakness _ muscle/joint pain _ numbness/tingling in hands/feet

_ neck pain _ back pain

Skin _ good _ rash _ ulcers _ dry skin

_ suspicious lesions _ easy bruising _ bleeding gum

Urinary _ good _ blood in urine _ painful urination _ frequent infection

_ leaking urine _ frequent urination _ incomplete emptying

_ I take waterpill

Gynecologic _ good _ abnormal bleeding – see front _ memory loss _insomnia

_ hot flashes _ vaginal dryness

_ mood swings/depression _ decreased libido

_ pain during sex _ odorous vaginal discharge

_ constant bulge in vagina _ pelvic pain

Psychiatric _ good _ depression _ severe anxiety