Total Women's Health & Wellness Center, Inc.

Name_____ Age_____ Date_____

Physician you are seeing

today_____

Physicians you have seen in the past:

_____

_____

REASON FOR TODAY'S VISIT:

_____

_____

CURRENT MEDICAL PROBLEMS:

_____

_____

List all CURRENT PRESCRIPTION MEDICINES (include dosage, reason you take it, who prescribed it):

_____

_____

List all OVER-THE-COUNTER MEDICINES, vitamins, and food supplements that you take:

_____

_____

ALLERGIES:

_____

_____

SENSITIVITIES:

_____

_____

List SURGERIES you have had (include year, surgeon, hospital)

_____

_____

Describe HOSPITALIZATIONS ILLNESSES not included above(include year, hospital)_____

_____

_____

Age of first period_____ Date of last normal period_____ No. of pregnancies___

Age of first period_____ Date of last normal period_____ No. of pregnancies_____

No. of live births_____ No. of children living _____

Birth control method_____Date of last pap_____ Done

Where_____

Date of last mammogram_____

Do you have now or any history of (circle)

Irregular periods Bad menstrual cramps Heavy periods Pelvic pain Infertility
Female trouble Hot flashes Vaginal dryness Vaginal discharge Vaginal odor
Vaginal itching Abnormal Pap Smear Breast problems Abnormal mammogram PMS

Who in your family has/had (circle if cause of death and write age of death):

Heart disease_____
Genetic disorder_____
Diabetes_____
Cancer_____
Thyroid Disease_____
Alcoholism_____
Mental Illness_____
Arthritis_____
Glaucoma_____
Asthma_____
Tuberculosis_____
Hypertension_____

Who lives in your household?_____

Where do/did you work?_____

How much do you weigh?_____ How much would you like to weigh?_____ Heaviest Weight?_____

Do /did you EXERCISE?_____ How much?_____ hrs/wk No. of years_____ Year you QUIT?_____

Do/did you SMOKE?_____ How Much?_____ packs/day No. of years_____ Year you Quit?_____

Do/did you drink ALCOHOL?_____ How Much?_____ drinks/week No. of years_____ Year you Quit?_____

Previous or current problem with alcohol?_____

AA?_____

Do/did you use (circle): Caffeine Nutrasweet Marijuana Cocaine Chewing tobacco Diet pills

Please Sign:_____ Date_____