Washington Women's Health Specialists

Part of Washington Township Medical Foundation

Name:	Reason for Visit:	Date of Visit:
Primary MD:	Preferred Pharmacy:	Date of Birth/Age:

ALLERGIES ❑ No known drug allergies

Medication	Reaction

MEDICATIONS (All – Including over-the-counter medications or herbal supplements; if needed, attach separate list)

Medication	Dosage	Reason for taking

GYN HEALTH HISTORY - Have you ***ever*** had any of the following?

	Yes	No	Date		Yes	No	Date
Cervical Cancer	❑	❑		Infertility	❑	❑	
Endometriosis	❑	❑		Ovarian Cancer	❑	❑	
Fibroids of the Uterus	❑	❑		Pelvic Inflammatory Disease	❑	❑	
Heavy or Irregular Periods	❑	❑		Uterine Cancer	❑	❑	
Incontinence of Urine	❑	❑		Other (please explain below)	❑	❑	
Comments/Treatment:							

MEDICAL HISTORY – Have you **ever** had any of the following?

	Yes	No		Yes	No
Autoimmune disorders	❑	❑	High Blood Pressure	❑	❑
Asthma	❑	❑	High Cholesterol	❑	❑
Blood Clots (also known as DVT or PE)	❑	❑	Intestinal problems	❑	❑
Breast Cancer	❑	❑	Kidney Stones	❑	❑
Breast Problems	❑	❑	Lung problems	❑	❑
Colon Cancer	❑	❑	Migraines	❑	❑
Diabetes	❑	❑	Osteoporosis/Osteopenia	❑	❑
Epilepsy	❑	❑	Psychiatric (ex. depression/anxiety)	❑	❑
Gallbladder problems	❑	❑	Thyroid problems	❑	❑
Gastrointestinal reflux (severe heartburn)	❑	❑	Ulcer	❑	❑
Heart Disease	❑	❑	Other (please explain below)	❑	❑
Comments/Treatment:					

SURGICAL HISTORY

Date	Type of Operation	Reason for Operation	Complications

FAMILY HISTORY – Does anyone in your family have:

	Yes	No	Family Member		Yes	No	Family Member
Autism	❑	❑		Heart Disease	❑	❑	
Birth Defects	❑	❑		High Cholesterol	❑	❑	
Breast Cancer	❑	❑		Hypertension	❑	❑	
Colon Cancer	❑	❑		Ovarian Cancer	❑	❑	
Diabetes	❑	❑		Stroke	❑	❑	
Genetic disorders	❑	❑		Other (please explain below)	❑	❑	
Comments:							

REV 2/2018

SOCIAL HISTORY

Relationship Status: ❑Married ❑Single ❑Domestic Partner ❑Divorced ❑Widowed

Are you currently sexually active: ❑Yes ❑No Number of sexual partners in the last two years: Male:____Female:_____

Current method of birth control:_____

Do you smoke (including vapor products), use tobacco products or smokeless tobacco? ❑Current ❑Past ❑Never

If CURRENT, how much do you smoke/chew per day?_____ If PAST, how many years ago did you quit?_____

Do you drink alcohol? ❑Yes ❑No If YES, how much and how often:_____

Do you use any street drugs (including marijuana)? ❑Yes ❑No If YES, what type and how often:_____

PREGNANCY HISTORY:

Times Pregnant _____ Term Births _____ Premature Births _____ Miscarriages _____ Abortions _____ Ectopics _____ Living Children _____

No.	Date (mm/dd/yyyy)	Wks Gest	Labor (hours)	Baby's Weight	Gender	Delivery Type (Vag or C/S)	Pain Meds	Complications
1.								
2.								
3.								
Comments:								

MENSTRUAL HISTORY:

Date of last menstrual period:_____ ❑Unsure ❑Menopausal: Age of Menopause:_____

Age of first period:_____ Number of days between periods:_____ Days of flow/bleeding:_____

Period Pattern: ❑ Regular ❑Irregular

Flow (check applicable): ❑Light ❑Medium ❑Heavy ❑Clots ❑Bleeding between periods

Menstrual Control: ❑Panty liner ❑Thin Pad ❑Maxi Pad ❑Hospital Pad ❑Tampon ❑Other

PREVENTATIVE HEALTH:

PAP HISTORY:

Date of most recent Pap smear _____

Was HPV testing done: ❑yes ❑no ❑ unsure What was the result? _____

Have you ever had an abnormal pap smear: ❑yes ❑no If yes, what was the result? _____

BREAST HEALTH:

Did you breast feed: ❑yes ❑no ❑ not applicable If yes, how long did you breastfeed? _____

When was your last mammogram? _____ ❑ not applicable

Have you ever had an abnormal mammogram? ❑yes ❑no If yes, what was the result?_____

STI History

Have you ever had sexually transmitted infection? ❑yes ❑no If yes, what was the result? _____

Patient's Signature:_____Date Signed_____

Print Patient Name:_____