WOMEN'S HEALTH SPECIALIST'S OF FREDERICK

Patient Name:____ Date of Birth:_______________

Primary Care Provider:___________________________ Preferred lab: **QUEST** **LABCORP**

Preferred Radiology Facility:______________________ Pharmacy Name/Location:____________________________

Gynecologic pain/issues that you need to discuss for today's visit: ____

Allergies: YES NO ; IF YES, what are you allergic to:______________________________________

Medications:

Drug Name	Strength	Frequency Taken

Gynecological History:

Date of Last Period:_________________ Frequency of Cycle (days):_________ Duration:___________

Age of first Period:___________ If menopausal, age at menopause_____ HPV vaccine: YES NO

Sexually Active: YES NO STIs/STDs: YES NO If **yes**, what kind of STI/STD:_________________________________

Current form of birth control method:_________________________

TEST	DATE LAST PERFORMED	NORMAL / ABNORMAL	RESULT IF ABNORMAL
PAP SMEAR			
HPV TESTING			
MAMMOGRAM			
BONE DENSITY			

Obstetric History:

Total Pregnancies:________ Births: _______ Miscarriages:________ Abortions:________ C-Sections:_________

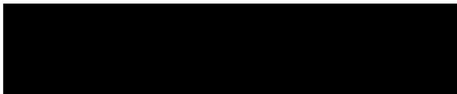
- ○ Bleeding between periods
- ○ Heavy Period
- ○ Extreme menstrual pain
- ○ Vaginal itching, burning, or discharge
- ○ Sexually active
  - Current sexual partner is: ○ Female ○ Male
  - Do you use condoms: ○ Yes ○ No
  - Other Birth control method used:_____________________
  - Interested in being screened for STDs ○ YES ○ NO
- ○ Wake in the night to go to the bathroom
- ○ Hot Flashes
- ○ Breast lump or nipple discharge
- ○ Painful Intercourse

Social History:

Smoking History: Never____ Former____ Current every day____

Marital Status: Single; Married; Divorced; Separated; Widowed; Domestic Partner

Alcohol Consumption: None____; 2-4 times a month; 2-3 times a week; _____4 or more times a week



Recreational Drug Use: ○ YES ○ NO

Patient Name:_______________________________________

Family Cancer History:

IF YES, complete below table:

RELATIVE	TYPE OF CANCER	AGE OF ONSET	**Maternal** or **Paternal**

Social History:

PAST SURGICAL HISTORY:____

PAST MEDICAL HISTORY:

___Acne ___Anemia ___Anesthesia Complications ___Anxiety

___Arthritis ___Asthma ___Bleeding Disorder ___Breast Cancer

___Breast Disease ___Diabetes ___Fibromyalgia ___Genitourinary Disease

___Hernia/Reflux ___HIV/AIDS ___Hypercholesterol ___Hypothyroidism

___Hyperthyroidism ___Hypertension ___IBS ___Neurologic Disorder

___Renal/Kidney Disease ___Lung Disease ___Stroke ___Tuberculosis

___Cancer: **TYPE:**_______________________________________

CURRENT MEDICAL ISSUES: (Please check all that apply)

Allergic:
_Frequent Sneezing
_Hives
_Itching

Cardiovascular:
_Arm Pain on Exertion
_Chest Pain on Exertion
_Chest Heaviness
_Irregular Heart Beats
_Known Heart Murmur
_Light-headed on Standing
_Shortness of Breath when lying down
_Swelling (edema)

Constitutional:
_Exercise Intolerance
_Fatigue
_Fever

Eyes:
_Dry Eyes
_Irritation
_Vision Change

ENT:
_Difficulty hearing
_Dizziness
_Dry mouth
_Ear Pain
_Frequent Infections
_Nose/Sinus Issues

Endocrine:
_Fatigue
_Increased thirst/hunger/urination

Gastrointestinal:
_Abdominal Pain
_Blood in Stool
_Change in Appetite
_Frequent indigestion
_Hemorrhoids
_Vomiting

Genitourinary
_Blood in Urine
_Difficult urinating
_Increased urinary frequency
_Urinary loss of control

Hematologic/Lymphatic:
_Easy bruising/ bleeding
_Swollen glands

Integumentary (Skin):
_Changes in Moles
_Dry Skin
_Eczema
_Growth/Lesions
_Rash

Musculoskeletal:
_Muscle Weakness
_Joint Pain
_Back Pain

Neurological:
_Dizziness
_Fainting
_Headaches/Migraines
_Memory loss
_Seizures
_Weakness

Psychiatric:
_Alcohol Overuse
_Anxiety/Stress
_Depression
_Mania
_Sleep Problems

Respiratory:
_Cough
_Coughing up blood
_Shortness of Breath
_Sleep Apnea
_Snoring
_Wheezing

Patient Signature:____ Date:________________________