Women to Women Health Care

Please fill out completely before arriving to your appointment or you may be asked to reschedule. Thank you.

Full Name: _____ Today's Date: _____

Date of birth: ____/____/____ E-Mail: _____

Pharmacy Name: _____ Phone: (_____) _____-_____

Pharmacy Location/Address: _____

GYNECOLOGIC HISTORY

Age of first period:	First day of last period:	Cycle Length:
Are your periods regular: Yes No	Flow: Light Moderate Heavy	Pain or cramping: Yes No
Method of birth control: ☐ Abstinence ☐ Condoms ☐ Depo Provera ☐ IUD ☐ Nexplanon ☐ Patch ☐ Pills ☐ Tubal ☐ Vaginal Ring ☐ None ☐ Vasectomy ☐ Withdraw	Are you sexually active: Yes No Any pain during sexual intercourse: Yes No	Have you ever been diagnosed with an STD: Yes No STD Type: __ Chlamydia __ Gonorrhea __ Hepatitis __ Herpes __HIV __ HPV __ Syphilis __ Trichomonas __ Other: When: Treatment:
Date of last Colonoscopy: ☐ Normal ☐ Abnormal	Date of last Mammogram: ☐ Normal ☐ Abnormal	
Date of last Pap smear: ☐ Normal ☐ Abnormal Positive HPV: Yes No	Date of last Bone Density: ☐ Normal ☐ Abnormal	
Past Abnormal Pap Smear: Yes No Date: _____ Results: _____ HPV: ☐ Negative ☐ Positive ☐ Have you been treated for an abnormal pap? Yes No Treatment Date: _____ Colposcopy: Yes No _____ Cryo: Yes No _____ LEEP: Yes No _____		
Sexual Partners: Male Female Both How many in the past year: Lifetime:	Daily Calcium Intake: Vitamin D Intake:	Do you perform Breast self exams: Yes No Date last performed:

OBSTETRIC HISTORY

Total number of Pregnancies: _____

Please list all pregnancies in order, including miscarriages, premature birth, stillbirths, ectopic (tubal) and abortions:

MM/DD/YYYY	Male/ Female	Type of Delivery	Length of Pregnancy	Length of Labor	Birth Weight	Hospital/Physician

Patient Name: _____

SOCIAL HISTORY

Do you smoke? Yes No	How many a day?	How long? Tried Quitting? Yes No # of days without a cigarette:
Do you drink alcohol? Yes No	What type?	How much? How often?
Caffeine? Yes No	What type?	How much? How often?
Recreational Drugs? Yes No	What type?	How much? How often?

CURRENT MEDICATIONS & VITAMINS

Please include as needed medications

Drug Name/Dose	Directions	Drug Name/Dose	Directions
1._____	_____	5._____	_____
2._____	_____	6._____	_____
3._____	_____	7._____	_____
4._____	_____	8._____	_____

DRUG ALLERGIES

Are you allergic to Latex? Yes No

Drug Name	Allergy Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

IMMUNIZATIONS

Date Given	Vaccines	Date Given	Vaccines
	Boostrix (Tetanus, Diphtheria, Pertussis)		MMR (Measles, Mumps, Rubella)
	Gardasil or Cervarix (HPV)		Pneumovax (Pneumonia)
	Havrix (Hepatitis A)		Varicella (Chicken Pox)
	Hepatitis B		Zostavax (Shingles)
	Influenza (Flu)		

Patient Name: _____

SURGICAL/HOSPITAL HISTORY
(Please exclude Obstetric history)

Date	Hospital/Facility	Procedure	Physician

FAMILY HISTORY

Are you adopted: Yes No
Has any relative had any of the following?

Disease/Disorder	Side of Family (circle)	Relative(who?)	Cause of Death/Age
Breast Cancer	**Maternal Paternal**		
Endometriosis	**Maternal Paternal**		
Diabetes	**Maternal Paternal**		
Heart Disease	**Maternal Paternal**		
Hypertension	**Maternal Paternal**		
Osteoporosis	**Maternal Paternal**		
Ovarian Cancer	**Maternal Paternal**		
Stroke	**Maternal Paternal**		
Thyroid Disease	**Maternal Paternal**		
Uterine Cancer	**Maternal Paternal**		
Deep Vein Thrombosis	**Maternal Paternal**		
Other:	**Maternal Paternal**		

PAST MEDICAL HISTORY

Have you ever had any of the following: Please check the box if 'Yes'

Anxiety/Depression ☐	DVT (Deep Vein Thrombosis) ☐	Hepatitis ☐	Stroke ☐
Asthma ☐	Diabetes ☐	Herpes ☐	Thyroid Disease ☐
Allergies ☐	Endometriosis ☐	Hypertension ☐	Other ☐
Bleeding Disorder ☐	Fibroids ☐	Migraines ☐	Other ☐
Breast Cancer ☐	Genital Warts ☐	Osteopenia ☐	
Cancer (Any) ☐	Heart Disease ☐	Osteoporosis ☐	