Kipuka o ke Ola

Established Patient Information Form- Women's Health

Patient Name: _____ _____ _____
Last Name First Name Middle Initial

Date of Birth: _____ **Age** _____ **Referring Physician:** _____

Primary Care Physician name and Phone number: _____

Reason for today's visit: ☐ Annual Exam ☐ Issue/concern

Please list any surgeries and/or hospitalizations since your last visit: _____

_____

Any changes to your Medical History? ☐ Yes ☐ No

ALLERGIES (medication, food, dye, latex, etc.): ○ **NO KNOWN ALLERGIES**

Allergies:	Reactions (anaphylaxis, hives, rash, etc.)

MEDICATIONS (please include all over the counter and prescribed medication and supplements. You may attach a list): ○ **NO MEDICATIONS**

Medication Name:	**Dose**	**Frequency**	**Route (oral, Topical, Etc)**	**Reason for taking this Medication:**

SOCIAL HISTORY:

Alcohol: ☐ None ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly Amount: _____
Tobacco/Vape/Chew: ☐ Yes ☐ No ☐ Former Amount/Frequency: _____
Street Drugs: ☐ Yes ☐ No ☐ Former Type/Frequency: _____
Exercise: ☐ Yes ☐ No ☐ Former Type/Frequency: _____

REVIEW OF SYSTEMS:

Are you currently having (check all that apply): ○ **NONE**

Constitutional
- ☐ Fever
- ☐ Fatigue
- ☐ Weight Gain
- ☐ Weight Loss

GYN
- ☐ Pain with Intercourse
- ☐ Genital Sores
- ☐ Pelvic Pain
- ☐ Vaginal Pain
- ☐ Genital Itching

Integumentary
- ☐ Rash
- ☐ Itching
- ☐ Abnormal Moles

Gastroenterology
- ☐ Abdominal Pain
- ☐ Loss of Appetite
- ☐ Heartburn
- ☐ Blood in Stool
- ☐ Loss of control of stool
- ☐ Vomiting
- ☐ Bloating

Eyes
- ☐ Eye Pain
- ☐ Loss of Vision

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Swelling of Legs

Breast
- ☐ Nipple Discharge
- ☐ Breast Pain
- ☐ Breast Lump

Genitourinary
- ☐ Urinary Urgency
- ☐ Urinary Frequency
- ☐ Painful Urination
- ☐ Urinary Incontinence
- ☐ Blood in Urine
- ☐ Incomplete Emptying
- ☐ Abnormal Urine Stream

Respiratory
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Endocrine
- ☐ Heat or Cold Intolerance
- ☐ Hot Flashes
- ☐ Abnormal Thirst

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Memory Loss

PREGNANCY HISTORY: ◯ **NO PREGNANCIES**

Please list number of: Pregnancies: _____

Please list number of: Living Children: _____ Miscarriages: _____ Abortions: _____ Ectopic: _____

Still Born: _____ Multiple Births (twins, etc.): _____ Number or Cesarean Deliveries _____

Date of Birth: _____ Type of Delivery: _____ Epidural? ☐ Yes ☐ No Birth Weight: _____ ☐ M ☐ F

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***Pregnancy History** (continued):*

Additional Births:

_____

_____

_____

_____

GYNECOLOGICAL HISTORY:

Have you had a Mammogram? ☐ Yes ☐ No If yes, please list when/where: _____

Date of last Pap smear: _____ Where: _____ Was the results normal? ☐ Yes ☐ No

Have you had an abnormal Pap smear? ☐ Yes ☐ No

Have you had a DEXA bone scan? ☐ Yes ☐ No If yes, please list when/where: _____

Have you ever completed a Colonoscopy? ☐ Yes ☐ No If yes, please list when/where: _____

Have you ever received the Gardasil Injection? ☐ Yes ☐ No

If yes, please list when/where and if you have received all three injections: _____

At what age did you start your period? _____ When was the first day of your last menstrual period? _____

Do you have your period monthly? ☐ Yes ☐ No How many days does your period last? _____

How many days between periods? _____ Days

How many pads _____/ tampons _____ are used on your heaviest day?

Are your periods painful ☐ Yes ☐ No If yes how do you treat your pain? _____

Have you ever had sex? ☐ Yes ☐ No Are you currently sexually active? ☐ Yes ☐ No

Please indicate your sexual partners: ☐ Male ☐ Female ☐ Both

What do you use for birth control? _____

Menopause:

At what age did you start to experience menopause symptoms? _____ ◯ **NO SYMPTOMS**

Did you have a hysterectomy? ☐ Yes ☐ No

Did you have your ovaries removed? ☐ Yes ☐ No Did you remove one or both? _____

Are you currently taking or previously taken hormones? ☐ Yes ☐ No

If yes, what type and how long have you used them? _____

Additional Social History:

Have you ever been sexually, physically, or emotionally abused? ☐ Yes ☐ No
Do you presently feel threatened by anyone? ☐ Yes ☐ No
Would you like counseling services? ☐ Yes ☐ No

What have you done for yourself in the past year? _____
_____
_____
_____

The above information is accurate to the best of my knowledge.

Patient name *(print)*: _____

Patient Signature: _____ Date: _____

Parent/legal guardian name*(print)*: _____

Parent/legal guardian signature: _____ Date: _____