

# Caring for Women, PC

Pt's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

With whom may we discuss test results or therapies? \_\_\_\_\_

1. GYNECOLOGICAL HISTORY: Any gynecological problems since your last examination?  Yes;  No (If yes, please explain)

-First day of last period \_\_\_\_\_ - Date of last Mammogram \_\_\_\_\_

- Duration of flow \_\_\_\_\_ - Date of last Pap Smear \_\_\_\_\_

- Time between periods \_\_\_\_\_ - Are you sexually active? \_\_\_\_\_

- Date of last Bone Density Scan \_\_\_\_\_ - Do you use contraception?  Yes;  No (If yes, type?) \_\_\_\_\_

2. MEDICAL HISTORY: Any medical problems since your last examination?  Yes;  No (If yes, please explain)

- Do you take calcium?  Yes;  No

- List current Medications  
(include vitamin and herbal supplements) \_\_\_\_\_

- List any Allergies to Medication \_\_\_\_\_

- Any Surgeries/Hospitalizations since your last examination? (If yes, please explain):

3. FAMILY HISTORY: Any changes to your family history since your last examination?  Yes;  No (If yes, please explain)  
(For example, breast cancer, ovarian cancer, uterine cancer and/or colon cancer?)

4. SOCIAL HISTORY: Any changes to your social history since your last examination?  Yes;  No

- Do you exercise regularly?  Yes;  No Current Occupation: \_\_\_\_\_

- Marital status?  Single  Married  Separated  Divorced  Widow  Other

- Do you smoke cigarettes?  Yes;  No If yes, at what age did you start? \_\_\_\_\_ Packs per day? \_\_\_\_\_

- Do you drink alcohol?  Yes;  No If yes, amount? \_\_\_\_\_ If yes, how often? \_\_\_\_\_

- Do you use drugs socially?  Yes;  No If yes, amount? \_\_\_\_\_ If yes, how often? \_\_\_\_\_

- Are you a victim of domestic violence or abuse in your present relationship?  Yes;  No Past Relationship?  Yes;  No

- Do you have a living will?  Yes;  No

5. REVIEW OF SYSTEMS

**Abdomen:**

Diarrhea?  Yes  No Constipation?  Yes  No Other: \_\_\_\_\_

**Genitourinary:**

Frequent urination?  Yes  No Urinary Incontinence?  Yes  No Other: \_\_\_\_\_

**Skin/breast:**

Lumps in breast?  Yes  No Nipple discharge?  Yes  No Other: \_\_\_\_\_

**Any other problems?**

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

(Signature of Provider)