

WOODWARD & ASSOCIATES, P.C.

Initial Patient History

NAME: _____ **BIRTH DATE:** _____ **SS#:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL PHONE:** _____

Occupation: _____ **Referred By:** _____

Spouse's Name: _____ **Spouse's Occupation:** _____

Date of Last Period: _____ **Date of Period prior to that:** _____ **Age of first menses:** _____

Are periods regular? (please circle) Yes/No **How often do they occur?** _____

How long are periods? _____ **days** **Flow: (please circle) Light/Medium/Heavy** **Cramping w/menses? Yes/No**

Number of pregnancies: _____ **Number of living children:** _____ **Stillbirths:** _____

Number of tubal pregnancies: _____ **Number of miscarriages:** _____ **Neonatal deaths:** _____

Are you having any of the following? (please circle all that apply)

Vaginal discharge External irritation Bleeding between periods Bleeding after intercourse

Bowel problems _____ Headaches Premenstrual irritability

Bladder problems: cystitis, leakage, Other _____ Menopausal symptoms (hot flashes, etc.)

Do you take hormones? **Yes/No** _____

Last pap smear (date) _____ **Results:** _____

Current contraceptive method: _____

Do you smoke? _____ **How much?** _____ **Do you Drink Alcohol?** _____ **How much?** _____

Are you having any problems with any of the following? (Please circle all that apply)

Head Eye Ears Nose Throat Asthma Pneumonia

Coughing Heart Murmur High blood pressure Rheumatic fever Thyroid Kidney Stones

Kidney infections Skin Bones Joints Other hormonal problems _____

Other medical problems: _____

Allergies/Medications/Past Surgical History

Are you allergic to any medications? If yes, which medications _____

Any allergies to other things? _____

Current medications: _____

Have you ever had surgery? **Y/N** If yes, please list type & date _____

Does any immediate family member have: (Please circle all that apply)

Diabetes High Blood Pressure Breast Cancer Ovarian Cancer Colon Cancer

Osteoporosis Heart Disease (please describe) _____

Other: _____

Husband's family history _____