WEST COUNTY
WOMENS HEALTHCARE
JULIEGOULDOBGYN.COM

Patient Name: _____ **Date of Birth:** _____ **Date of Visit:** _____

Reason for Visit: _____ **Current Occupation:** _____

How did you hear about our practice? _____

Medication List

Medication Name (include over the counter medication)	Strength/ Dose (mg)	Number of pills per dose	Number of times per day

Past Medical History									
Diabetes	☐	Yes	☐	No	Emphysema/COPD	☐	Yes	☐	No
High Blood Pressure	☐	Yes	☐	No	MRSA	☐	Yes	☐	No
Stroke	☐	Yes	☐	No	Depression/Bipolar	☐	Yes	☐	No
Heart Disease/Heart Attack	☐	Yes	☐	No	Hepatitis B or C	☐	Yes	☐	No
Kidney Stones/Infections	☐	Yes	☐	No	Sleep Apnea	☐	Yes	☐	No
Thyroid Disease	☐	Yes	☐	No	Breast Disease	☐	Yes	☐	No
Seizures	☐	Yes	☐	No	Liver Disease	☐	Yes	☐	No
Bleeding Disorder	☐	Yes	☐	No	High Cholesterol	☐	Yes	☐	No
Mitral Valve Prolapse	☐	Yes	☐	No	Stomach/Bowel problems	☐	Yes	☐	No
Tuberculosis	☐	Yes	☐	No	Glaucoma	☐	Yes	☐	No
Migraines	☐	Yes	☐	No	Osteoporosis	☐	Yes	☐	No
Asthma	☐	Yes	☐	No	Cancer	☐	Yes	☐	No
Anxiety	☐	Yes	☐	No	Details:				
Alcohol/Drug Problems		Yes		No					

Allergies:

Do you have a latex allergy? Yes No

Drug/Non-Drug Allergy	Allergic Reaction

Surgical History

Previous Surgeries	Date or Age at the time
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family Medical History

				(relationship to you)
Cancer	____ Yes	___ No		
High Blood Pressure	____ Yes	___ No		
Heart Problems	____ Yes	___ No		
Clotting Problem	____ Yes	___ No		
Bleeding Problem	____ Yes	___ No		
Diabetes	____ Yes	___ No		
Breast Cancer	____ Yes	___ No		
Ovarian Cancer	____ Yes	___ No		
Colon Cancer	____ Yes	___ No		
Uterine Cancer	____ Yes	___ No		
Other Cancer: _____	____ Yes	___ No		

Social History

Use of Tobacco:	____Never Smoker ____Former Smoker How long has it been since you last smoked? _____ ____Current Smoker
Use of Drugs:	Other recreational drugs? ____ No ____ Yes If yes, what types? _____
Use of Alcohol:	Do you drink alcohol? ____No ____Yes # of drinks/day _____
Marital Status:	___Single ___Married ___Separated ___Divorced ___Widowed

Menstrual History:

First day of last menstrual period: __/__/__

Frequency between periods: <21 days 21-35 days >35 days Irregular

Duration: 1 day 2-7 days >7 days No menses

Flow: Light Heavy

Pain with period: No pain Moderate Severe

Do you require pain medication? Yes No

Age 1st period started: _____

Health Maintenance

Date of last PAP smear: _____ Gardasil Vaccine ____Yes ____No

Date of last mammogram: _____

Date of last DEXA: _____

Date of last colonoscopy: _____

Gynecologic History Have you ever had any of the following? (Check if yes)

___Abnormal PAP smear
___Cryosurgery of LEEP procedure on cervix
___Pain with intercourse
___Fibroids
___Endometriosis
___Surgery on female organs
___Difficulty holding urine
___Abnormal vaginal bleeding
___Infertility
___Infection of pelvic organs

Sexual History

Are you sexually active? Yes No

Your partner is: male female both

You are: single married/partnered separated widowed

STD History Have you have been diagnosed with a sexually transmitted disease? Yes No

If Yes, please check below:

___Gonorrhea ___Chlamydia ___Genital Warts ___HIV
___Herpes ___Syphilis ___HPV

Contraceptive History Check the methods you have used.

Past	Present		Past	Present	
___	___	Pills	___	___	Implanon/Norplant
___	___	IUD	___	___	Natural Family Planning
___	___	Diaphram	___	___	Tubal Ligation
___	___	DepoProvera	___	___	Vasectomy
___	___	Condoms	___	___	Foam/Spermicide

Obstetrical History

Total times pregnant: _____ Total Living Children: ____

Total deliveries: _____ Number of C-Sections: _____

Spontaneous Miscarriages: ____ Ectopic pregnancy: _____

Elective Abortions: ____

Patient Signature: _____ Date: _____