Wake Women's Health

Established Patient Health Form

Today's date: _____

Name:_____Birth date:_____Primary care doctor:_____

Reason for today's visit/Any concerns? ☐Annual_____

_____

Date of 1st day of last menstrual period:	PREGNANCY HISTORY: Do you think you could be pregnant today? ☐Yes ☐No
If you are in menopause, when did your periods stop?_____ If you still have periods: Periods occur every _____ days, last for _____days	_____Total # of pregnancies _____Miscarriages _____Vaginal births _____Abortions _____Cesarean sections _____ Ectopic (tubal) pregnancy
Child(s) names:	

What type of birth control are you currently using?

Do you currently have any of the following:	
☐ Heavy periods, irregularity, spotting, or pain with periods	☐ Endometriosis
☐ Bloating, irritability, or other symptoms at or around time of period	☐ Uterine fibroids
☐ Hot flashes or night sweats	☐ Ovarian cysts/tumors

When was your last:			Any new allegies?	Reaction
Pap smear?	Colonoscopy?			
HPV test?	Last Flu shot?			
Mammogram?	Last Tetanus?			
Bone density test?				

Please list only CHANGES to the following below since your last visit:	
Medical history (new problems or conditions):	Surgeries:
Hospitalizations:	Family History:

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Current medications (including over-the-counter drugs, vitamins & herbals):

IF YOUR MEDICATIONS ARE ALREADY IN OUR COMPUTER SYSTEM, PLEASE LIST ONLY NEW MEDS

Name	Strength	Taken how often

REVIEW OF SYSTEMS: Please mark an "X" if you **currently** have:	
GENERAL	☐Fevers ☐Chills ☐Night sweats ☐Fatigue ☐Unintended weight loss/gain
EYES	☐Visual changes ☐Double vision ☐ Blind spots ☐Eye pain
EARS, NOSE, MOUTH & THROAT	☐ Frequent nose bleeds ☐Ringing in ears ☐Ear pain/discharge ☐Hearing loss ☐ Bleeding in gums ☐ Sore throat ☐Difficulty swallowing ☐ Sinus pain ☐ Dentures
CARDIOVASCULAR	☐ Chest pain with exercise ☐ Shortness of breath ☐ Palpitations ☐ Feeling faint
RESPIRATORY	☐ Cough ☐Wheeze ☐Blood in sputum
GASTROINTESTINAL	☐ Severe abdominal pain ☐ Decreased appetite ☐New abdominal bloating ☐Bloody stools ☐ Nausea/vomiting ☐Vomiting blood ☐Diarrhea ☐Constipation ☐Change in bowel habits ☐ Accidental loss of stool or gas
URINARY	☐ Pain with urination ☐ Accidental loss of urine ☐ Blood in urine ☐ Frequent nighttime urination
MUSCULOSKELETAL	☐New muscle or joint pain ☐Limb weakness or paralysis ☐Joint swelling
SKIN	☐ Skin rash ☐New mole
NEURO	☐New headaches ☐ Dizziness ☐ Seizures ☐Numbness in extremities ☐Tremors
PSYCH	☐Serious depressed mood ☐Excess anxiety ☐ Thoughts of hurting self ☐Hallucinations
BREAST	☐Breast pain ☐New lump ☐ Nipple discharge ☐Skin changes
ENDOCRINE	☐Cold intolerance ☐Heat intolerance ☐Excess thirst
HEMATOLOGIC	☐ Anemia ☐Abnormal bruising or bleeding ☐Enlarged lymph nodes
IMMUNOLOGIC	☐Hay fever ☐Persistent Infections ☐HIV exposure