

**PREVENTIVE WOMEN'S HEALTH
874 FOX DRIVE
WINCHESTER, VA 22603**

Name: _____ Birth date: _____ / _____ / _____
Last First Middle Month Day Year

FAMILY HISTORY

HAVE ANY OF YOUR RELATIVES EVER HAD ANY OF THE FOLLOWING?

1) Epilepsy	5) Diabetes	11) Osteoporosis	17) Alcohol/Drug Addiction	Mother: _____
2) Headaches	6) Thyroid Disease	12) Arthritis	18) Hepatitis	Father: _____
3) Mental Illness (depression/anxiety/other)	7) Hayfever	13) Heart Disease	19) Cancer	Brother: _____
4) Kidney Disease	8) Asthma	14) Stroke	20) Tuberculosis	Sister: _____
	9) Anemia	15) High Blood Pressure	21) HIV	
	10) Bleeds Easily	16) High Cholesterol		

MEDICAL HISTORY

ALLERGIES: Do you have any allergies to:

Medications (please list) _____

Food _____

Environmental _____

Latex _____

MEDICATIONS TAKEN REGULARLY: (include allergy shots, birth control, pain control, laxatives, vitamins, diet pills, antidepressants, inhalers, etc.)

Name of Provider prescribing medication: _____ Phone: _____

Medication/Dosage: _____

Medication/Dosage: _____

SURGERIES/ACCIDENTS/HOSPITALIZATIONS: _____

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

<input type="checkbox"/> Decreased hearing	<input type="checkbox"/> Persistent nausea / Vomiting	<input type="checkbox"/> Bone fracture / joint injury	<input type="checkbox"/> : Have you ever...
<input type="checkbox"/> Ringing in ear	<input type="checkbox"/> Abdominal pain - chronic	<input type="checkbox"/> Foot pain	<input type="checkbox"/> been restricted from sports or physical exercise?
<input type="checkbox"/> Dizzy spells	<input type="checkbox"/> Gall bladder trouble	<input type="checkbox"/> Rashes	<input type="checkbox"/> fainted during exercise?
<input type="checkbox"/> Vision problems	<input type="checkbox"/> Jaundice / Hepatitis	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> had chest pain or a racing heart during exercise?
<input type="checkbox"/> Severe head injury / concussion	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> wheezed or coughed during exercise?
<input type="checkbox"/> Nose bleeds - recurrent	<input type="checkbox"/> Constipation	<input type="checkbox"/> Polio	<input type="checkbox"/> had a family member die of sudden death before age 50?
<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Crohn's /Colitis	<input type="checkbox"/> Measles	<input type="checkbox"/> had signs or symptoms of marfans?
<input type="checkbox"/> Sore throats - frequent	<input type="checkbox"/> Bloody or tarry stools	<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Hoarseness - prolonged	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Aids / HIV	
<input type="checkbox"/> Hayfever / Allergies	<input type="checkbox"/> Hernia	<input type="checkbox"/> Sleeping or concentration difficulty	
<input type="checkbox"/> Pneumonia / Pleurisy	<input type="checkbox"/> Urinating frequently	<input type="checkbox"/> Depression	
<input type="checkbox"/> Bronchitis / Chronic cough	<input type="checkbox"/> with leakage	<input type="checkbox"/> Anxiety	
<input type="checkbox"/> Asthma / Wheezing	<input type="checkbox"/> with pain	<input type="checkbox"/> Agitation	
<input type="checkbox"/> Shortness of breath:	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Self injury/cutting	
<input type="checkbox"/> on exertion	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Phobias	
<input type="checkbox"/> lying flat	<input type="checkbox"/> Urine infections - frequent	<input type="checkbox"/> Feelings of worthlessness	
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Sexually transmitted diseases	<input type="checkbox"/> History of alcohol / drug addiction	
<input type="checkbox"/> High blood pressure	Type: _____	<input type="checkbox"/> Anorexia	
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Weight-loss	<input type="checkbox"/> Bulimia	
<input type="checkbox"/> Irregular pulse	<input type="checkbox"/> Gain - recent	<input type="checkbox"/> Emotional / physical / sexual abuse	
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Anemia	SOCIAL HISTORY:	
<input type="checkbox"/> Leg pain - when walking	<input type="checkbox"/> Bruise easily	Do you now or have you ever consumed:	
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Blood transfusions	Cigarettes	
<input type="checkbox"/> Cold, numb feet or hands	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Y <input type="checkbox"/> N Pk./day _____	
<input type="checkbox"/> Hair loss	<input type="checkbox"/> Cancer	Alcohol	
<input type="checkbox"/> Loss of appetite - recent	<input type="checkbox"/> Chronic fatigue	<input type="checkbox"/> Y <input type="checkbox"/> N Drinks/wk. _____	
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Diabetes	Caffeine	
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Y <input type="checkbox"/> N Cups/day _____	
<input type="checkbox"/> Peptic ulcer	<input type="checkbox"/> Seizures	Street Drugs	
	<input type="checkbox"/> Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> Tremor / hands shaking		
	<input type="checkbox"/> Numbness / tingling sensations		
	<input type="checkbox"/> Headaches - frequent		
	<input type="checkbox"/> Arthritis / Rheumatism		
	<input type="checkbox"/> Back pain - recurrent		

FEMALES:

Menstrual flow:

Reg. Irreg. Pain / cramps

Days of flow _____ Length of cycle _____

Date - 1st day of last period _____

Pain / bleeding during or after sex

Number of:

Pregnancies _____ Abortions _____

Miscariages _____ Live births _____

Birth control method _____

B.C. pill (name) _____

Date of last PAP test _____

Other: _____