

## WomanCare

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

**IN THE EVENT OF A LIFE THREATENING MEDICAL EMERGENCY WOULD YOU BE WILLING TO ACCEPT BLOOD OR BLOOD PRODUCTS?** YES \_\_\_\_\_ NO \_\_\_\_\_  
 if you answer no, please see the receptionist before continuing to fill out form

Reason for appointment: \_\_\_\_\_

Date of the first day of your last period: \_\_\_\_\_ Periods usually occur every \_\_\_\_\_ days, and last \_\_\_\_\_ days.

Date of last pelvic exam and pap: \_\_\_\_\_ Age of first menstrual period: \_\_\_\_\_ Age of menopause: \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_ Bone density scan: \_\_\_\_\_ Cholesterol: \_\_\_\_\_

Do you have bleeding between your periods or any problems with your periods? Cramps? \_\_\_\_\_

If sexually active, do you have discomfort or problems with intercourse? \_\_\_\_\_

Age of onset of sexual activity? \_\_\_\_\_ Number of sexual partners during the last 5 years? \_\_\_\_\_

What is your method of birth control? (Circle) Pills Vasectomy IUD TubLigation Condoms Nuvaring Other: \_\_\_\_\_

Number of Pregnancies: \_\_\_\_\_ Miscarriages/Abortions: \_\_\_\_\_ Live Births: \_\_\_\_\_ Adopted: \_\_\_\_\_

Complications of pregnancy: \_\_\_\_\_ Type of Delivery: (Circle) Vaginal or C-Section

Infertility Problems: \_\_\_\_\_

List people living with you:

Name	How related to you	Age	Occupation

Have you had childhood immunizations? \_\_\_\_\_ Three Gardiall (HPV) Vaccines? \_\_\_\_\_

When was your last tetanus booster? \_\_\_\_\_

When was your last TB skin test? \_\_\_\_\_ Result: \_\_\_\_\_

Have you ever had any of the following (for family check only lines indicated):

	Self	Family	Who		Self
Cancer (Type)				Breast lumps	
Diabetes				Migraine headaches	
High blood pressure				Unusual vaginal bleeding	
Heart Disease / Stroke				Pelvic infections	
High cholesterol				Abnormal pap smear	
Liver / Gall bladder disease				Frequent vaginal infections	
Epilepsy				Bladder / Kidney infections	
Multiple births				Depression	
Birth defects				Sexually transmitted disease	
Thyroid problems				Leaking urine / incontinence	

Do you smoke cigarettes? (Circle) Yes No Use alcohol? Yes No Do you use drugs such as marijuana? Yes No

Surgeries or hospitalizations: \_\_\_\_\_

Allergies: \_\_\_\_\_

List of Current Medications	Dosage	List of Current Medications	Dosage