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 menstual 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 TublLigation Condoms Nuvaring Other: _____

Number of Pregnancies: _____ Miscarriages/Abortions: _____ Live Births: _____ Adopted: _____

Complications of pregnancy: _____ Type of Deliv*ery*

Infertiity 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
Cancer (Type)			
Diabetes			
High blood pressure			
Heart Disease / Stroke			
High cholesterol			
Liver / Gall bladder disease			
Epilepsy			
Multiple births			
Birth defects			
Thyroid problems			

	Self
Breast lumps	
Migraine headaches	
Unusual vaginal bleeding	
Pelvic infections	
Abnormal pap smear	
Frequent vaginal infections	
Bladder / Kidney infections	
Depression	
Sexually transmitted disease	
Leaking urine / incontinence	

Do you smoke cigarettes?

Use alcohol?

Do you use drugs such as marijuana?

Surgeries or hospitalizations: _____

Allergies: _____

List of Current Medications	Dosage	List of Current Medications	Dosage