CAROLINA WOMEN'S HEALTH

NAME	SSN	DOB
CURRENT MEDICATIONS:		

Method of Birth Control:	Alcohol: No Moderate Daily
Drug Allergies:	Smoke: Yes No _____ pks/day
	Marijuana or other illegal drugs: Y N
Last Menstrual Period:	Sexually Active: Yes No
Past Surgeries:	

PERSONAL HISTORY

Have you ever had:	YES	NO	Have you ever had:	YES	NO
Abnormal Pap			Gonorrhea		
Measles			Chlamydia		
Mumps			Syphilis		
Chicken Pox			Pelvic Inflammatory Disease		
Scarlet Fever			HIV (AIDS)		
Pneumonia			Hepatitis or Jaundice		
Kidney Infection			Depression or PMS		
Kidney Stones			Anxiety Attack		
Polio			Diabetes		
Tuberculosis			Endometriosis		
Herpes			Thyroid Disease		
Vaginal Warts/Condyloma			Cancer		

FAMILY HISTORY

Has any relative ever had:	YES	NO	Has any relative ever had:	YES	NO
Breast Cancer			Stroke		
Ovarian Cancer			Heart Disease		
Uterine Cancer			Endometriosis		
Colon Cancer			Fibroids		
Other Cancer			Depression		
Diabetes			Osteoporosis		
High Blood Pressure			Blood Clot (DVT)		
High Cholesterol			Genetic Disorders		

MENSTRUAL HISTORY

Age Period Began	No. Days Periods Lasts
Regualr Cycles: Yes No	Flow: Light Medium Heavy
Frequency: every _____ days	Any Irregularities:
Cramps: Yes No	

PREGNANCY HISTORY

YEAR	Vaginal or C-Section	Weeks GA	Sex	Weight	Complications

Signed_____ Date_____

Review of Systems

Circle for any **Current** conditions you would like to discuss today

Constitutional

Unexplained weight gain/unexplained weight loss
Heat or cold intolerance/loss of balance

Ear, Nose, Throat

Blurred vision/loss of hering/Hoarsness

Cardiovascular

Chest pain/shortness of breath when lying flat/ swelling of legs or feet

Respiratory

Shortness of breath/prolonged cough/coughing up blood

Gastroenterology/GI

Diarrhea >2 weeks/rectal bleeding/Tar colored/ Black stools/Heartburn/Nausea

Skin

Persistent rash/Change in moles

Social:

Tobacco: No Yes_____packs per day
Alcohol: No Yes_____drinks per day
Occupation:_____

Marital Status:

Single/Married/Divorced/Widow/Seperated

Last Menustrual Period:_____

Muscoskeletal/Neurologic

Joint pain/muscle weakness/seizures/headaches

Psychiatric

Depression (new)/Crying Spells/Anxiety/Panic Attacks

Hematology/Lymph

Easy bruising/Frequesnt nose bleeds/swollen lymph nodes

Gynecological

Bleeding or spotting between periods/Heavy periods/Periods that last >7 days/Pain with sex/ Severe menstrual cramps/Bleeding after sex

Breast

Spontaneous nipple discharge/Masses/Pain

Genitourinary

Blood in urine/Pain with urination/Leakage of urine/Having to get up more than 2 times at night to void

Please list your Medications:

_____
_____
_____

Please list any new problems or surgeries since your last Visit:

_____
_____

In the last two weeks, how often have you been bothered by the following problems:

1. Little interest or pleasure in doing things: ___not at all ___several days ___more than half the days ___nearly every day
2. Feeling down, depressed, irritable, hopeless: ___not at all ___several days ___more than half the days ___nearly every day

Name:_____ Date of Birth:_____ Age:____ Today's Date:_____

Signature:_____ Physician's Signature:_____

Family History

Please indicate any positives in your family history. Include *parents, siblings, aunts, uncles, grandparents & first cousins.* Please write in who is/was affected and the age of onset. Thanks!'

Condition	Relationship to you	Age of Onset
Diabetes		
High Blood Pressure		
Thyroid Disease		
Osteoporosis		
Broken Hip or "Dowager's Hump		
Breast Cancer		
Ovarian Cancer		
Colon Cancer		
Heart Disease		
Stroke		
Other		

Patient Signature:_____ Date:_____