

## Health Evaluation

- This questionnaire is intended to help you inform your doctor about your current and past medical condition.
- You **MUST** complete this form prior to being seen for your appointment.

Name: \_\_\_\_\_ DOB: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Name of Spouse/Partner: \_\_\_\_\_ Referred By: \_\_\_\_\_

Primary Physician: \_\_\_\_\_  I do not have a primary physician.

Reason for visit: \_\_\_\_\_ Other Physician: \_\_\_\_\_

### PAST MEDICAL HISTORY: (Check if you have ever had or been diagnosed with any of the following?)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Epilepsy/Seizures          | <input type="checkbox"/> Mental Illness               |
| <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Eye problems               | <input type="checkbox"/> Osteoporosis                 |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Fibrocystic Breast Disease | <input type="checkbox"/> Ovarian Cysts                |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Gallbladder Disease        | <input type="checkbox"/> Pneumonia                    |
| <input type="checkbox"/> Bowel Troubles         | <input type="checkbox"/> Genital Warts              | <input type="checkbox"/> Premenstrual Syndrome        |
| <input type="checkbox"/> Breast Cancer          | <input type="checkbox"/> Gonorrhea                  | <input type="checkbox"/> Rheumatic fever              |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Heart problems             | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Cervical Dysplasia     | <input type="checkbox"/> Heart murmur               | <input type="checkbox"/> Thyroid Disease              |
| <input type="checkbox"/> Chlamydia              | <input type="checkbox"/> Herpes, Genital            | <input type="checkbox"/> Transfusions                 |
| <input type="checkbox"/> Chronic Lung Disease   | <input type="checkbox"/> High blood pressure        | <input type="checkbox"/> Trichomonas                  |
| <input type="checkbox"/> Deep Venous Thrombosis | <input type="checkbox"/> Infertility                | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Irritable Bowel Syndrome   | <input type="checkbox"/> Ulcer                        |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Kidney Infection           | <input type="checkbox"/> Uterine Fibroids             |
| <input type="checkbox"/> Elevated Cholesterol   | <input type="checkbox"/> Kidney Stones              | <input type="checkbox"/> Yellow jaundice or hepatitis |
| <input type="checkbox"/> Endometriosis          |   |   |
| <input type="checkbox"/> Other _____            |   |   |

### HEALTH MAINTENANCE

Last Bone Density? Year: \_\_\_\_\_  Normal  Abnormal \_\_\_\_\_

Last Colonoscopy Year: \_\_\_\_\_  Normal  Abnormal \_\_\_\_\_

Last Mammogram: Year: \_\_\_\_\_  Normal  Abnormal \_\_\_\_\_

Last Pap Smear: Year: \_\_\_\_\_  Normal  Abnormal \_\_\_\_\_

Previous abnormal mammograms?  No  Yes, when? \_\_\_\_\_ Any treatment? \_\_\_\_\_

Previous abnormal pap smears?  No  Yes, when? \_\_\_\_\_ Any treatment? \_\_\_\_\_

### PAST SURGICAL HISTORY: (Please check any that you have had and what year)

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Appendix _____         | <input type="checkbox"/> D&C _____         | <input type="checkbox"/> Hysterectomy _____ | <input type="checkbox"/> Tubal Ligation _____ |
| <input type="checkbox"/> Breast _____           | <input type="checkbox"/> Gallbladder _____ | <input type="checkbox"/> Ovary _____        | <input type="checkbox"/> Vaginal Repair _____ |
| <input type="checkbox"/> Cesarean section _____ | <input type="checkbox"/> Heart _____       | <input type="checkbox"/> Tonsils _____      |   |
| <input type="checkbox"/> Other _____            |  |   |   |

ALLERGIES TO MEDICATIONS:  No Known Allergies \_\_\_\_\_

### FAMILY HISTORY: (Please check box if any of your family members have had the following and indicate what relation)

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Breast Cancer _____ | <input type="checkbox"/> Heart disease _____       | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Colon Cancer _____  | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Diabetes _____      | <input type="checkbox"/> Ovarian Cancer _____      |                                       |

### GYNECOLOGICAL HISTORY: (Fill in blanks or check boxes where appropriate)

Age at first menstrual period: \_\_\_\_ years Days between the first day of each period: \_\_\_\_ days Length of each period: \_\_\_\_ days

Flow:  Light  Medium  Heavy # Tampons \_\_\_\_ # Pads \_\_\_\_

Last normal menstrual period: \_\_\_\_/\_\_\_\_/\_\_\_\_

Menopausal Status:  Premenopausal  Perimenopausal  Postmenopausal Age at Menopause \_\_\_\_\_

Do you use contraception?  Yes  No (If yes, please check type)

- |  |                                       |                                  |   |
|--|---------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Depo Provera | <input type="checkbox"/> Foam    | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> NuvaRing            | <input type="checkbox"/> IUD          | <input type="checkbox"/> Condoms | <input type="checkbox"/> Vasectomy      |
| <input type="checkbox"/> Ortho Evra          | <input type="checkbox"/> Diaphragm    |                                  | <input type="checkbox"/> Other _____    |

Breakthrough bleeding:  Yes  No Clots:  Yes  No

(OVER)

**OBSTETRICAL HISTORY:**

Pregnancies: \_\_\_\_\_ Full-Term: \_\_\_\_\_ Pre-Term: \_\_\_\_\_ Abortions: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Tubal Pregnancies: \_\_\_\_\_ Multiple: \_\_\_\_\_ Living: \_\_\_\_\_

Date	Weeks	Sex	Weight	Route of Delivery	Complications
____/____/____	_____	_____	_____	_____	_____
____/____/____	_____	_____	_____	_____	_____
____/____/____	_____	_____	_____	_____	_____

**SOCIAL HISTORY:**

Marital Status:  Dating  Divorced  Married  Separated  Widowed  
 Not Dating  Engaged  Partnered  Single

Are you sexually active?  Yes  No Age of 1<sup>st</sup> intercourse: \_\_\_\_\_ Marital problems:  Yes  No

Education Level: \_\_\_\_\_ grade  
 Graduated High School  GED  Some College  
 Graduated College - 2 YR  Graduated College - 4 YR  Postgraduate

Alcohol Use  Never  Current  Former Amount \_\_\_\_\_ Started \_\_\_\_\_ Stopped \_\_\_\_\_  
Recreation Drug Use  Never  Current  Former Type \_\_\_\_\_ Started \_\_\_\_\_ Stopped \_\_\_\_\_  
Tobacco Use  Never  Current  Former Amount \_\_\_\_\_ Started \_\_\_\_\_ Stopped \_\_\_\_\_  
Do you exercise regularly  Yes  No Do you use your seat belt?  Yes  No

**MEDICATIONS:** (Please list all medications, even over the counter, vitamins, herbal remedies, etc., with dosages)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**REVIEW OF SYSTEMS:** (Check if you currently have any of the following symptoms)

**CONSTITUTIONAL**

- Fatigue/Weakness
- Fever
- Weight loss
- Weight gain

**EYES**

- Vision problem

**HEENT**

- Headaches

**BREAST**

- Breast Discharge
- Breast Lumps
- Breast Pain
- Leaking Milk

**CARDIOVASCULAR**

- Chest pain
- Heart murmur
- Short of breath on exertion
- Palpitations
- Swelling in legs

**RESPIRATORY**

- Cough
- Shortness of breath
- Spitting up blood
- Wheezing

**GASTROINTESTINAL**

- Abdominal pain
- Bloody stool
- Constipation
- Diarrhea
- Heartburn
- Hemorrhoids
- Inability to hold stool

- Nausea
- Reflux
- Vomiting

**GENITOURINARY**

- Bleeding between periods
- Blood in urine
- Decreased sex drive
- Difficulty starting to urinate
- Heavy periods
- Hot flashes
- Irregular periods
- Leaking urine with cough, etc.
- Leaking urine with urgency
- Not having periods
- Pain with intercourse
- Painful periods
- Painful urination
- Spotting with or after intercourse
- Vaginal discharge
- Vaginal dryness
- Urinary frequency
- Urinary urgency

**INTEGUMENTARY**

- Acne
- Changes in existing lesions/moles
- Itching
- New skin lesions
- Rash

**NEUROLOGIC**

- Dizziness
- Seizures
- Syncope (Fainting/Passing out)

**MUSCULOSKELETAL**

- Back pain
- Bone fracture
- Joint pain
- Joint swelling
- Muscle pain
- Muscular weakness
- Numbness
- Sciatic pain

**ENDOCRINE**

- Changes in hair texture
- Changes in skin texture
- Cold intolerance
- Excessive hair growth
- Excessive thirst
- Excessive urination
- Heat intolerance
- Loss of hair

**PSYCHIATRIC**

- Anxiety
- Depression
- Difficulty sleeping

**HEMATOLOGIC**

- Anemia
- Easy bleeding
- Easy bruising
- Swollen lymph nodes

**ALLERGIC-IMMUNOLOGIC**

- Sinus allergy symptoms

DATE: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

PATIENT INFORMATION

NAME: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE #: \_\_\_\_\_ WORK PHONE #: \_\_\_\_\_

CELL PHONE #: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_

HUSBAND NAME: \_\_\_\_\_ HUSBAND EMPLOYER: \_\_\_\_\_

NEAREST LIVING RELATIVE: \_\_\_\_\_ PHONE #: \_\_\_\_\_  
(OTHER THAN HUSBAND)

I WILL RECEIVE BLOOD IF MEDICALLY NECESSARY  YES OR  NO

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY

NAME: \_\_\_\_\_

POLICYHOLDER'S NAME: \_\_\_\_\_ DOB \_\_\_\_\_

POLICYHOLDER'S EMPLOYER: \_\_\_\_\_

PATIENT'S RELATIONSHIP TO POLICYHOLDER: SELF SPOUSE CHILD

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY NAME: \_\_\_\_\_

POLICYHOLDER'S NAME: \_\_\_\_\_ DOB \_\_\_\_\_

POLICYHOLDER'S EMPLOYER: \_\_\_\_\_

PATIENT'S RELATIONSHIP TO POLICYHOLDER: SELF SPOUSE CHILD

INSURANCE AUTHORIZATION

I request that payment under the medical insurance program be made to the Woman's Clinic on any bills for services furnished me during the effective period of this authorization and authorize the above named provider to release the Social Security Administration or its intermediaries or carriers any information needed for this claim or related medicare claim. I further permit a copy of this authorization to be used in place of the original. This authorization is further to apply to all private insurance claims, for my care.

\_\_\_\_\_ X \_\_\_\_\_ X  
Date Patient Signature Patient Signature if a Minor

I am responsible for all financial obligations of health services for the above patient, and for reimbursement and payment of claims from my insurance company. If for any reason the account should become delinquent, I agree to pay for all billing charges, interest charges, collection costs, and legal fees.

\_\_\_\_\_ X \_\_\_\_\_  
Date Patient Signature or Responsible Party ccmv575(10/04)