Mercy Clinic Women's Health

O'FALLON:
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Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____

Home Phone: _____ – _____ – _____ Work Phone: _____ – _____ – _____

Referred by: _____

Pharmacy Name and Number: _____

Primary Care Doctor: _____ Date of last visit? _____

Initial Women's Health Questionnaire

Reason for Today's Visit: _____

GYNECOLOGIC HISTORY:

Date of first day of your last period? _____ Age of first period? _____

How often are your periods? _____ How long do they last? _____

Are you currently sexually active? ☐ No ☐ Yes

If so what form of contraception are you using *(including tubal sterilization or vasectomy in your partner)*?

_____

Are your partners: ☐ Men ☐ Women ☐ Both How many sexual partners have you had in the last year? _____

Have you ever had a Hysterectomy? ☐ No ☐ Yes If so, were your ovaries removed? ☐ No ☐ Yes

Do you have any questions regarding sexual relations? ☐ No ☐ Yes

Date of last PAP smear? _____ ☐ Normal ☐ Abnormal

Have you ever had an abnormal PAP smear? ☐ No ☐ Yes Date: _____

Have you ever had a sexually transmitted disease? ☐ No ☐ Yes

☐ Herpes ☐ Gonorrhea ☐ Chlamydia ☐ HIV ☐ Genital Warts ☐ Syphilis ☐ Pelvic Inflammatory Disease

☐ Other: _____

Date of last mammogram: _____ ☐ Normal ☐ Abnormal

Date of last Bone Density: _____ Date of last Colonoscopy: _____

OB HISTORY:

How many times have you been pregnant? _____ Number of vaginal deliveries? _____ Number of Cesarean sections? _____

Reason for Cesarean section? _____

Number of living children? _____ Number of adopted children? _____ Largest baby weight? _____

Number of miscarriages? _____ Number of stillbirths? _____ Number of abortions? _____ Number of tubal pregnancies? _____

OB HISTORY *(continued):*

Any problems with your pregnancies or deliveries? _____

Any problems with postpartum depression? _____

MEDICAL ILLNESS PROBLEMS:

Please check any of the following conditions that you have *(now or in the past)*:

☐ Asthma
☐ Chronic Lung Disease
☐ Heart Disease
☐ Reflux or Ulcers
☐ Crohn's
☐ Ulcerative Colitis
☐ Breast Disease
☐ Liver Disease/Hepatitis
☐ Kidney Disease
☐ Eating Disorder
☐ Thrombosis/Blood Clots
☐ Diabetes
☐ Thyroid Disease
☐ High Blood Pressure
☐ Stroke
☐ Migraines
☐ Anemia or Transfusion
☐ Depression or Anxiety
☐ Seizures or Epilepsy
☐ Glaucoma
☐ Fracture or broken bone
☐ High Cholesterol
☐ Osteopenia/ Osteoporosis

Other: _____

_____

SURGERY, HOSPITALIZATIONS OR INJURIES:

Date	**Procedure/Reason**	**Hospital**	**Complications**

MEDICATIONS: *(including vitamins, herbal and any over the counter)*

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Are you ALLERGIC to any medications? _____

Please check the IMMUNIZATIONS that are up to date: ☐ Tetanus ☐ Pertussis ☐ Varicella ☐ Hepatits A ☐ Hepatitis B ☐ Gardasil

FAMILY HISTORY: *(Any parents, siblings, grandparents, aunts and uncles have any of the following?)*

☐ Diabetes ☐ Heart Disease ☐ High blood pressure ☐ Stroke
☐ Breast cancer ☐ Ovarian cancer ☐ Colon cancer ☐ High cholesterol
☐ Blood clots ☐ Mental Illness ☐ Osteoporosis ☐ Blood Disorders
☐ Uterine cancer ☐ Cancer *(Type):* _____

Other: _____

SOCIAL HISTORY:

Do you smoke? ☐ No ☐ Yes Packs per day: _____ How long?_____

Do you drink alcohol? ☐ No ☐ Rarely ☐ Occasionally ☐ Often ☐ Daily

Do you use drugs socially? ☐ No ☐ Rarely ☐ Occasionally ☐ Often ☐ Daily

☐ Marijuana ☐ Cocaine ☐ Crack ☐ Heroine ☐ Methamphetamine

☐ Other: _____ Last Used:_____

Do you exercise regularly? ☐ No ☐ Yes

Are you: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Current or most recent occupation: _____

Have you been physically or mentally abused by your spouse or partner? ☐ No ☐ Yes

Have you ever been sexually abused, raped or date raped? ☐ No ☐ Yes If so, do you wish to discuss this? ☐ No ☐ Yes

REVIEW OF SYSTEMS:

Please "X" any of the following that you are experiencing:

☐ Weight changes	☐ Palpitations	☐ Leaking urine	☐ Depression
☐ Fever	☐ Cough	☐ Blood in urine	☐ Crying spells
☐ Fatigue	☐ Coughing up blood	☐ Urinary urgency	☐ Anxiety
☐ Vision changes	☐ Wheezing	☐ Pain with urination	☐ Breast masses
☐ Loss of gas	☐ Swelling of legs	☐ Vaginal dryness	☐ Pain in breast
☐ Sinus problem	☐ Frequent diarrhea	☐ Seizures	☐ Dry skin
☐ Sore throat	☐ Nausea/vomiting	☐ Headache	☐ Hair loss/growth
☐ Dental problems	☐ Constipation	☐ Painful intercourse	☐ Hot flushes
☐ Shortness of breath	☐ Leaking stool	☐ Bleeding problems	☐ Abnormal thirst
☐ Chest pain	☐ Bloody stool	☐ Sleep problems	

ANY CONCERNS OR QUESTIONS?

_____

_____

_____

_____

Patient: _____ Date: _____

(Signature)