Premier Women's Health Center

"Making a difference in women's lives!"

Bryan Myers, MD, PC
Ashley DeWitt, DO, PC
Courtney Murray, DO, PC
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Initial Patient History

PLEASE BRING RELEVANT RECORDS AND/OR PREVIOUS TEST/TREATMENTS TO YOUR APPOINTMENT

PATIENT'S INFORMATION

Last Name _____ First _____ Middle _____ Date of Visit ____/____/____

Address _____ City _____ State _____ Zip _____

Age _____ Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____

Name of practitioner who referred you or who would like notes sent to _____ Fax Number _____

Address _____ City _____ State _____ Zip _____

PHARMACY INFORMATION

Name _____ City _____ Phone Number _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone Number _____

WHAT IS THE REASON FOR YOUR VISIT TODAY? (Check all that apply)

- ☐ Well woman annual gyn care
- ☐ Birth control options
- ☐ Abnormal bleeding
- ☐ Vaginal discharge/odor
- ☐ Vulvar pain/itching
- ☐ Pelvic pain
- ☐ Fibroid management
- ☐ Menopause symptoms
- ☐ Surgery consult
- ☐ Second opinion
- ☐ Abnormal pap smear
- ☐ Other _____

If you have symptoms, please describe how long, what treatments you have tried and any other important details.

_____

OBSTETRIC HISTORY

Please list the number of pregnancies which you have had:

Total number pregnancies
which are as listed below _____
Full-term deliveries _____
Premature deliveries _____
Twin deliveries _____

Miscarriages _____
(year(s), if applicable) _____
Termination _____
(year(s), if applicable) _____

Tubal pregnancies _____
(year(s), if applicable) _____
If yes, did you get treatment with: _____
☐ medication ☐ laparoscopy ☐ open surgery

Molar pregnancies _____
(year(s), if applicable) _____
Living children _____

Month/Year	Type of Delivery V=Vaginal C=C-section F=Forceps VA=Vacuum B=Breech	Weeks at Delivery	Baby's Sex	Baby's Weight	Complications of Delivery
1.	☐V ☐C ☐F ☐VA ☐B		☐M ☐F	___lb ___oz	
2.	☐V ☐C ☐F ☐VA ☐B		☐M ☐F	___lb ___oz	
3.	☐V ☐C ☐F ☐VA ☐B		☐M ☐F	___lb ___oz	
4.	☐V ☐C ☐F ☐VA ☐B		☐M ☐F	___lb ___oz	
5.	☐V ☐C ☐F ☐VA ☐B		☐M ☐F	___lb ___oz	
6.	☐V ☐C ☐F ☐VA ☐B		☐M ☐F	___lb ___oz	

Possible other obstetric information _____

_____

SEXUAL/CONTRACEPTION HISTORY

Sexual preference – who do you have sex with? (check): ☐ Men ☐ Women ☐ Both (both men and women)

Have you ever had vaginal sexual intercourse before? ☐ Yes ☐ No

Have you had sexual intercourse in the past 3 months? ☐ Yes ☐ No

How many partners do you currently have? _____ Any new partners within the last 3 months? ☐ Yes ☐ No

Current birth control method?

☐ None ☐ Diaphragm ☐ Male/Female condoms ☐ Birth control pills ☐ Implanon/Nexplanon
☐ DepoProvera injection ☐ Birth control patch ☐ Nuva Ring ☐ Mirena/IUD ☐ Skyla/Levonorgestrel
☐ Copper Paragard IUD ☐ Tubal ligation ☐ Essure ☐ Vasectomy
☐ Natural family planning/Rhythm method ☐ Other _____

How often do you use condoms? ☐ Never ☐ Sometimes ☐ Always

Are you currently trying to become pregnant? ☐ Yes ☐ No

Have you ever had any of the following infections?

☐ Genital warts ☐ Syphilis ☐ Hepatitis B ☐ Hepatitis C ☐ HIV/AIDS ☐ Gonorrhea
☐ Chlamydia ☐ Mycoplasma ☐ HPV ☐ Trichomonas ☐ Pelvic inflammatory disease (PID)
☐ Tubo-ovarian abscess (TOA) ☐ Genital herpes

Do you have any pain or discomfort during intercourse? ☐ Yes ☐ No
If yes, please describe your pain _____
If yes, is this: ☐ New problem ☐ Ongoing problem

Do you have any concerns or questions about sex such as pain or decreased sexual desire? ☐ Yes ☐ No
If yes, please describe _____

MENSTRUAL HISTORY

Are you still having a period? ☐ Yes ☐ No

IF YES:

At what age did you begin your period? _____
When was the first date of your last period? _____
Do you have regular predictable periods? ☐ Yes ☐ No
How many days do you typically bleed? _____
How often do your periods occur? _____

Do you have any bleeding or spotting between periods? ☐ Yes ☐ No
Do you have any bleeding after sex? ☐ Yes ☐ No

Describe your flow: ☐ Light ☐ Moderate ☐ Heavy
Is your period painful? ☐ Yes ☐ No
If yes, please describe _____

IF NO:

At what age did you stop having regular periods? _____
What is the reason? (please check)
☐ Menopause ☐ Hysterectomy ☐ Unknown
☐ Other _____
_____
_____
_____

Have you had any spotting or bleeding after menopause or hysterectomy? ☐ Yes ☐ No

Have you had any spotting or bleeding after menopause or hysterectomy? ☐ Yes ☐ No

Have you ever been on hormonal therapy (estrogen and/or progesterone?) ☐ Yes ☐ No

HEALTH MAINTENANCE HISTORY

When was your last pap smear? _____ Was it normal? ☐ Yes ☐ No
Have you ever had an abnormal pap smear? ☐ Yes ☐ No
Have you ever had: (Check all that apply and give date)
☐ Colposcopy _____ ☐ Cryotherapy _____ ☐ LEEP _____ ☐ Cone biopsy _____

When was your last:
Mammogram _____ ☐ Never had one Was it normal? ☐ Yes ☐ No

Colonoscopy _____ ☐ Never had one Was it normal? ☐ Yes ☐ No
DEXA (bone density scan) _____ ☐ Never had one Was it normal? ☐ Yes ☐ No
HIV test _____ ☐ Never had one What were the results? _____

Have you completed vaccination for Hepatitis B? ☐ Yes ☐ No

Have you completed vaccination for HPV (Gardasil/Cervarix/other)? ☐ Yes ☐ No

MEDICAL HISTORY (Please check all health problems which you have or have had previously)

☐ Acid reflux/ulcers
☐ Anemia
☐ Anxiety/depression
☐ Arthritis
☐ Asthma/lung problems
☐ Bleeding disorder
☐ Blood clots
☐ Bloody stools
☐ Cancer – Breast
☐ Cancer – Ovarian
☐ Cancer – Uterine
☐ Cancer – Colon
☐ Cancer – Lung
☐ Cancer – Other _____
☐ Diabetes
☐ Headaches/migraines
☐ Heart disease
☐ Heart attack
☐ Hemorrhoids
☐ Hepatitis
☐ High cholesterol
☐ High blood pressure
☐ HIV
☐ Kidney disease
☐ Liver disease
☐ Osteoporosis
☐ Seizures
☐ Sexually transmitted infection
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Other _____

SURGERIES

Please list all surgical procedures that you have had. Please include the date, reason for surgery and type of surgery:

Date	Type of Surgery	Reason

FAMILY HISTORY

	List relationship to you and age at his/her diagnosis
☐ Anemia	
☐ Asthma/lung problems	
☐ Blood clots	
☐ Cancer – Breast	
☐ Cancer – Ovarian	
☐ Cancer – Uterine	
☐ Cancer – Colon	
☐ Cancer – Lung	
☐ Cancer – Other _____	
☐ Diabetes	
☐ Heart disease	
☐ Heart attack	
☐ High cholesterol	
☐ High blood pressure	
☐ Kidney disease	
☐ Liver disease	
☐ Mental illness	

☐ Seizures
☐ Stroke
☐ Thyroid disease
☐ Other _____

SOCIAL HISTORY/SAFTEY

Do you have any religious or cultural preferences that may impact your care? ☐ Yes ☐ No

If yes, please describe _____

Are you: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ In a relationship ☐ Other _____

Have you ever been hit, slapped, kicked or physically hurt by someone? ☐ Yes ☐ No

Are you in a relationship with a person who threatens or physically hurts you? ☐ Yes ☐ No

Has anyone forced you to have sexual activities that made you feel uncomfortable? ☐ Yes ☐ No

What is your profession/occupation? _____

What are your hobbies/activities? _____

Do you follow a special diet? ☐ Yes ☐ No If yes, please describe _____

How often do you exercise? _____ Type: ☐ Weight-bearing ☐ Aerobic ☐ Other _____

Do you wear seatbelts? ☐ Yes ☐ No

Do you drink caffeine (soda, tea, coffee)? ☐ Yes ☐ No If yes, number of cups per day _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week _____

Have you ever felt the need to cut down on drinking? ☐ Yes ☐ No

Have you ever felt annoyed by criticism of your drinking? ☐ Yes ☐ No

Have you ever had guilty feelings about your drinking? ☐ Yes ☐ No

Do you ever take a morning eye opener (a drink first thing In the morning to steady your nerves or get rid of a hangover)? ☐ Yes ☐ No

Have you ever smoked cigarettes or used tobacco? ☐ Yes, currently ☐ Yes, but quit ☐ No, never

How many cigarettes per day? _____ How many years have you smoked? _____

If you smoke, would you like help quitting? ☐ Yes ☐ No

Do you use any of the following: ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ LSD ☐ Mushrooms

☐ Ecstasy ☐ Other "uppers" ☐ Other "downers" ☐ None

ALLERGIES

Do you have any allergies to any medications or foods? ☐ Yes ☐ No If yes, please list and describe the reaction.

Allergy	Reaction	Allergy	Reaction

MEDICATIONS

Name	Dose, Route, Frequency

REVIEW OF SYSTEMS

Please check any of the following symptoms that you experience presently or chronically.

Constitution
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Unexpected weight change

Head and Neck
- ☐ Congestion
- ☐ Hearing loss
- ☐ Mouth sores
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Eye itching
- ☐ Sensitivity to light
- ☐ Visual problems

Respiratory
- ☐ Cough
- ☐ Sleep apnea
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Blood in sputum
- ☐ Other _____

Cardiovascular
- ☐ Murmur
- ☐ Chest pain
- ☐ Palpitations
- ☐ Other _____

Gastrointestinal
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool/dark tarry stools
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Any change in stool
- ☐ Leakage of stool
- ☐ Other _____

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Glucose/Sugar problems
- ☐ Hair loss
- ☐ Excessive hair growth
- ☐ Other _____

Urinary
- ☐ Pain/burning on urinatino
- ☐ Frequent urination
  If so, how many times/day? _____
- ☐ Urgency to urinate
- ☐ Blood in urine
- ☐ Frequent bladder or kidney infections
- ☐ Urinary dribbling or difficulty urinating
- ☐ Urinary incontinence
- ☐ Other _____

Gynecologic
- ☐ Abnormal vaginal discharge or odor
- ☐ Burning or vulvar/vaginal discomfort
- ☐ Vaginal dryness
- ☐ Vaginal itching
- ☐ Genital lesions, bumps or ulcers
- ☐ Pain or discomfort with intercourse
- ☐ Recurrent yeast/bacterial infections
- ☐ Breast mass, tenderness, nipple discharge
- ☐ Other _____

Skin
- ☐ Color change
- ☐ Rash
- ☐ Wound
- ☐ Other _____

Central nervous system
- ☐ Migraine headaches with aura
- ☐ Migraine headaches without aura
- ☐ Weakness or numbness
- ☐ Seizures
- ☐ Other _____

Hematological
- ☐ Immune compromised
- ☐ Bruise or bleed easily
- ☐ Other _____

Mood
- ☐ Suicidal thoughts
- ☐ Thoughts of hurting others
- ☐ Decreased interest in doing things
- ☐ Anxiety
- ☐ Other _____

Other
- ☐ Insomnia or difficulty sleeping
- ☐ Irritability
- ☐ Hot flashes or night sweats
- ☐ Unplanned weight loss
- ☐ Unplanned weight gain
- ☐ Other _____

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Annual Gynecological Update

Name: _____ DOB: _____ Age: _____ Date: _____

Mailing Address or P.O. Box: _____

City _____ State _____ Zip Code: _____

Welcome Back! Please take a few minutes to fill out this form to help us update your records.

Reason for today's visit? _____ Annual Exam _____ Problem Visit

Please list any new medical problems: _____
What was the first date of your last period? _____
Please list all allergies: _____
Any new medical problems in your family? _____
Social status/Life changes (divorce/death/etc.)? _____
Please list all surgeries: _____
Please list all current medications: _____
Please list all allergies to medications: _____

Allergic to latex?	_____ Yes	_____ No	
Do you smoke cigarettes?	_____ Yes	_____ No	If so, how much per day? _____
Do you drink alcohol?	_____ Yes	_____ No	If so, how much per week? _____
Do you use street drugs?	_____ Yes	_____ No	
Problems with violence at home?	_____ Yes	_____ No	

General	_____ Weight loss	_____ Weight gain	_____ Fever	_____ Fatigue
HEENT	_____ Vision changes	_____ Hearing loss	_____ Sore throat	
CV	_____ Chest pain/pressure	_____ Irregular heartbeat	_____ Swelling of legs	
Resp	_____ Shortness of breath	_____ Chronic cough	_____ Spitting of blood	
GI	_____ Bloody stool	_____ Nausea/Indigestion	_____ Vomiting	_____ Diarrhea
Urinary	_____ Frequent urination	_____ Painful urination	_____ Loss of urine	
MS	_____ Muscle pain	_____ Joint pain	_____ Swelling of joint(s)	
Skin	_____ Rash	_____ Changes in color/size of mole(s)		
Neuro/psycl	_____ Headaches	_____ Depression/Crying spells		
Endocrine	_____ Appetite changes	_____ Excessive thirst		
Hematology	_____ Excessive bleeding	_____ Easy bruising	_____ Enlarged lymph nodes	

Do you perform month self-breast exams? _____ Yes _____ No
Do you exercise three 3x/week or more? _____ Yes _____ No
Last Mammogram check: _____ Last Bone Density testing: _____
For those over 40, date of last sigmoidoscopy/colonscopy/stool checked for blood? _____
Does your insurance cover routine, preventative gynecological care? _____ Yes _____ No
What pharmacy do you use for prescriptions? _____
What physician/clinic do you use for primary care? _____

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Today's Date: _____

Patient's name: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Name of Spouse (if you are under 21, name of parent): _____

Insurance Information

Do you have insurance? _____ Name of insurance: _____

Subscriber name: _____ SS#: _____ Date of Birth: _____

Your relationship to subscriber: _____ Subscriber phone: _____

Subscriber mailing address: _____

Insurance ID#: _____ Group #: _____

Secondary insurance/Name of company: _____

Subscriber name: _____ SS#: _____ Date of Birth: _____

Your relationship to subscriber: _____ Subscriber phone: _____

Subscriber mailing address: _____

Insurance ID#: _____ Group #: _____

Who is your primary physician? _____ Phone: _____

Who is responsible for this bill? _____

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Privacy Practices Notice of Acknowledgement

Name: _____

Acknowledgement

_____ I acknowledge that I have been offered the Notice of Privacy Practices but declined.

_____ I acknowledge that I have been offered the Notice of Privacy Practices.

I give my permission to speak to the following on any medical issues:

	Name
_____ My spouse	_____
_____ My child/children	_____
_____ My caregiver	_____
_____ Other	_____

Check all that apply.

_____ I give my permission to leave messages on my answering machine or with anyone answering my personal phone.

_____ I give my permission to contact me at my place of employment. If I am unavailable, I give permission for a message to be left to return the call.

_____ I give my permission for my physician to fax any information regarding me to another physician's office that may be covering for my doctor or a physician that I have been referred to.

_____ I give my permission for my pharmacy to be contacted regarding my medications. My pharmacy is:

_____ (pharmacy/city)

I will notify this office in writing (verbal will not be accepted) if there is any change in my above permission.

_____ Name

_____ Date