PATIENT HISTORY FROM

NAME_____

REASON FOR VISIT_____

PAST MEDICAL HISTORY (PLEASE LIST ALL MEDICAL DIAGNOSIS AND DATE OCCURED)

PAST SURGICAL HISTORY (PLEASE LIST ALL SURGERIES/DATES)

MEDICATIONS (PLEASE LIST ALL MEDICATION YOU ARE CURRENTLY TAKING)

Pharmacy Name and Phone #

ALLERGIES

Do you have drug allergies? Yes □ No □ If yes, please list: _____

Other allergies: _____

FAMILY HISTORY (PLEASE CHECK ALL THAT APPLY, IF YES,EXPLAIN)

	Cancer	
	Heart Disease	
	Diabetes	
	Other	

REPRODUCTIVE HISTORY

- Date of Last Menstrual Period_____
- Age at First Menstrual Period_____
- If menstrual period has stopped, age of last period_____
- Sexually Active? Yes □ No □
- Type of Contraception: _____
- Are Your Periods Regular? Yes□ No□

  If No, Please Explain _____
- Do You Experience Clots While Menstruating? Yes□ No□

  If Yes, Please Explain _____
- Do You Have Problems With Break Through Bleeding? Yes□ No□

  If Yes, Please Explain _____
- Are You On Hormone Replacement Therapy? Yes□ No□

  If Yes, Name of Drug and Dosage _____

Total # of Pregnancy(ies)		Full Term Birth(s)		Premature Birth(s)	
Abortion(s)		Miscarriage(s)			

	Child's Name	Date of Birth	Birth Weight	Doctor's Name	Delivery Method	Complication
1.						
2.						
3.						
4.						
5.						
6.						
7.						

SOCIAL HISTORY

Marital Status: Single □ Married □ Divorced □ Separated □ Other_____

Do You Smoke? Yes □ No □ If Yes, How Many Packs Per Day:_____

Do You Drink? Yes □ No □ Use Drugs? Yes □ No □

Have You Experienced Depression or Domestic Violence? Please Explain Below (confidentiality is guaranteed)

_____

_____

SCREENING QUESTIONNAIRE

Please Check "Yes" or "No"

1. Do You Have Heavy Periods? _____ Yes □ No □
2. Do You Have Pain With Periods?_____ Yes □ No □
3. Do You Have Pain With Intercourse?_____ Yes □ No □
4. Are You Interested in Permanent Contraception?_____ Yes □ No □
5. Do You Have Fibroids?_____ Yes □ No □
6. Do You Leak Urine?_____ Yes □ No □
7. Do You Leak Urine With a Strong Urge on the Way to the Bathroom?_____ Yes □ No □
8. Do You Leak Urine When You Cough, Sneeze, Laugh, Lift or Exercise?_____ Yes □ No □
9. Do You Wear Pads to Protect Your Clothes From Urine Leaking?_____ Yes □ No □
10. Do You Urinate Frequently Throughout the Day?_____ Yes □ No □
11. Do You Wake Up at Night to Urinate?_____ Yes □ No □

WeCare
Medical Associates

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

HISTORY OF EXAMS	DATE/YEAR	PHYSICIAN/OFFICE
Last known Annual Exam:		
Last Mammogram:		
Last Bone Scan:		
Last Colonoscopy:		
Last known Dental Exam:		
Last known Eye Exam/Diabetic Eye Exam:		
Last Abdominal Aortic Aneurysm(AAA) Screening:		
Diabetes - Hemaglobin A1C:		

IMMUNIZATIONS		
	Date	Location
Flu Vaccine		
Pneumonia Vaccine		
Varicella (chicken pox) Vaccine		
Tetnus Vaccine		

FALL SCREEN					
Have you fallen in the past 6 months?	Yes	No			
Do you worry about falling?	Yes	No			

DEPRESSION SCREENING					
Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly Every Day	
1. Little interest or pleasure in doing things	0	1	2	3	
2. Feeling down, depressed or hopeless	0	1	2	3	
	Total Score:				

PLEASE BRING ALL MEDICATIONS IN THEIR BOTTLES TO EVERY VISIT

Patient Signature: _____ **Date** _____