ADVANCED WOMEN'S OBGYN ASSOCIATES
Interim Health History Data

Patient name: _____ **Birth date:** _____ **Today's Date:** _____

Any new family history since your last annual exam?

Any pregnancies since your last annual exam?

Any new medical problems or surgeries since your last annual exam?

Have you had any of the following since your last annual exam?

- ☐ Weight changes
- ☐ Fatigue or weakness
- ☐ Fever
- ☐ Skin rash
- ☐ Itching
- ☐ Skin dryness
- ☐ Hair loss
- ☐ Excess hair growth
- ☐ Breast lump or swelling
- ☐ Breast pain
- ☐ Discharge from nipple(s)
- ☐ Headaches
- ☐ Dizziness
- ☐ Visual problems
- ☐ Bloody nose
- ☐ Bleeding gums
- ☐ Neck pain or mass
- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Fainting
- ☐ Varicose veins
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Chest pain
- ☐ Appetite changes
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Frequent urination
- ☐ Accidental urination
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Abnormal vaginal discharge
- ☐ Pain in vulvar area
- ☐ Pelvic pain
- ☐ Painful periods
- ☐ Pain during sex
- ☐ Heavy periods
- ☐ Frequent periods
- ☐ Irregular periods
- ☐ Lack of periods
- ☐ Low sex drive
- ☐ Hot flashes/night sweats
- ☐ Vaginal dryness
- ☐ Tender or painful muscles
- ☐ Muscle weakness
- ☐ Swelling of arms or legs
- ☐ Tingling sensation
- ☐ Depressed mood
- ☐ Anxiety
- ☐ Hallucinations
- ☐ Urge to hurt yourself
- ☐ Other (Specify)

_____

Gynecologic information:

Last normal menstrual period:_____ Type of contraception: _____

Menstrual abnormalities: ☐ Heavy ☐ Irregular ☐ Bleeding between periods or after intercourse

☐ Severe premenstrual symptoms: _____

Do you perform self-breast exams? ☐ Yes ☐ No

Do you experience pelvic pain, painful intercourse or painful periods? ☐ Yes ☐ No

If yes, please describe: _____

Last mammogram: _____ ☐ Never Last colonoscopy: _____ ☐ Never

Medications: Please list name of medicine, dose and frequency of use.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family physician: _____ When was your last visit there? _____

Allergies to medicines, latex, shellfish, x-ray dyes, iodine or peanuts: _____

Indicate volume of: Smoking _____ Drinking _____ Drug usage _____

Do you ever feel unsafe or afraid of someone? ☐ Yes ☐ No

Are you having any other women's health issues you would like to discuss with the physician today? ☐ Yes ☐ No

If yes, please describe: _____

_____

For office use only:

Physician reviewed: _____ Date: _____

☐ Kornstein ☐ Pliskow ☐ Dai ☐ J Ackerman ☐ R Ackerman ☐ Valdescruz