NAPLES WOMEN'S CENTER: ESTABLISHED PATIENT MEDICAL HISTORY FORM

Name:_____ Date of Birth:_____ Age:_____ Today's Date:_____

Reason for visit: Well Woman Exam **OR** Problem Visit: _____

(**PLEASE NOTE**: Extra charges may/will occur if both a Well Woman exam and Problem visit are discussed on the same day)

Current Medications (with dosages):

Medication Allergies: _____

Surgeries Since Last Visit:_____ **History of Hysterectomy**? ☐ Yes ☐ No
Number of Pregnancies: _____

Date of last period _____ Cycle Length: every _____ day(s) Lasting _____ day(s)

Periods are: ☐ Regular ☐ Irregular ☐ Painful

Flow is: ☐ Light ☐ Moderate ☐ Heavy ☐ Very Heavy

Are you sexually active? ☐ Yes ☐ No ☐ Never **New Partners?** ☐ Yes ☐ No **Number of Partners**:____

Current Method of Birth Control:

☐ Condoms ☐ Natural Family Planning ☐ Pills: _____ ☐ Vasectomy (Partner) ☐ Depo Provera
☐ IUD: Brand _____ Year inserted ____ ☐ Tubal/ Essure ☐ Vaginal Ring ☐ Cervical Cap
☐ Sponge ☐ Spermicide ☐ Withdrawal ☐ Other ☐ None

Please list the Month/Year for the following tests performed:

Pap smear _____ Mammogram_____ Bone Density Scan _____ Colonoscopy _____

Social History:

Tobacco use ☐ Yes ☐ No If yes, _____ pack(s) per day for _____ year(s)
Alcohol use ☐ Yes ☐ No If yes, _____ drink(s) per day/week/month
Caffeine ☐ Yes ☐ No If yes, _____ caffeinated drinks (coffee, tea, soda) per day/week/month
Exercise ☐ Yes ☐ No Type(s) and frequency_____

Do you have any of the following symptoms today?

☐ Yes ☐ No Generally healthy
☐ Yes ☐ No Recent weight gain/loss of 25 lbs.
☐ Yes ☐ No Fever
☐ Yes ☐ No Vision problems (excluding glasses)
☐ Yes ☐ No Sinus problems
☐ Yes ☐ No Hearing loss
☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Varicose Veins
☐ Yes ☐ No Shortness of breath
☐ Yes ☐ No Chronic Cough
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Constipation
☐ Yes ☐ No Blood in stools
☐ Yes ☐ No Heartburn/reflux
☐ Yes ☐ No Abnormal Frequent urination
☐ Yes ☐ No Burning w/ urination
☐ Yes ☐ No Incontinence
☐ Yes ☐ No Abnormal Urinary Urgency
☐ Yes ☐ No Bladder infection
☐ Yes ☐ No Abdominal pains
☐ Yes ☐ No Abnormal vaginal discharge
☐ Yes ☐ No Irregular vaginal bleeding
☐ Yes ☐ No Pelvic pain
☐ Yes ☐ No Painful intercourse
☐ Yes ☐ No Breast lumps
☐ Yes ☐ No Back pain
☐ Yes ☐ No Joint/muscle pain
☐ Yes ☐ No Depression/anxiety

Current Pharmacy: Name:_____ Location:_____ Phone:_____

Preferred Lab: Name:_____ Location:_____ Phone:_____

_____ _____
Patient Signature Date