NAPLES WOMEN'S CENTER: ESTABLISHED PATIENT MEDICAL HISTORY FORM

Name:_____ Date of Birth:_____ 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)

Medications (with dosages):

Medication Allergies: _____

New Surgeries Since Last Visit:_____

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

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_____
Recreational Drug use ☐ 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

NAPLES WOMEN'S CENTER
A HealthLynked Company

PELVIC/RECTAL EXAMINATION CONSENT

Patient Name: _____ DOB: _____

I understand that my medical care may require a pelvic (and/or) rectal examination defined as a series of tasks that comprise an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation.

By my signature below, I give my express consent to any and all medically appropriate pelvis/rectal examinations as defined above to be conducted now or in the future by a healthcare provider, medical student, or student receiving training as a healthcare provider that is employed by or contracted by:

NAPLES WOMEN'S CENTER

1265 Creekside Pkwy, Suite 200

Naples, FL 34108

Patient Signature: _____ Date: _____ Time: _____

Witness Signature: _____ Date: _____

This office is compliant with and regulated by the Board of Medicine Rule Chapter 64B8 and 64B15, Florida Administrative Code.

Form Date: 6/26/20