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

Current Pharmacy: Name:________________ Location:____________________ Phone:__________________

Preferred Lab: Name:________________ Location:____________________ Phone:__________________

____ ________________________________

Patient Signature Date