PHYSICIANS TO WOMEN, INC.

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HEALTH HISTORY UPDATE

PATIENT NAME_____ **DOB**_____ **Today's Date** _____

Preferred Pharmacy: _____
Primary Care Physician: _____
Other Physicians involved in your care: _____

Please help us update your medical record by completing the following questionnaire

In the past year (or since your last visit) have you had any of the following?

I. New medical illness / diagnosis? ❑ Yes ❑ No If yes, please list:_____

II. Surgery? ❑ Yes ❑ No If yes, what surgery did you have? _____

III. Emergency Room visits? ❑ Yes ❑ No If yes, for what reason? _____

IV. Hospitalizations? ❑ Yes ❑ No If yes, for what reason?_____

V. MEDICATIONS: Please list all medicines and/or supplements you are taking:

Name	DOSE	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VI. MEDICATION ALLERGIES

_____ Reaction _____
_____ Reaction_____
_____ Reaction_____

VII. SOCIAL HISTORY

Do you use tobacco? ❑ Yes ❑ No Type (Cigarettes, Vapor, etc) _____ Amount _____
Have you quit tobacco use in the last year? If yes, date: _____

Do you drink alcohol? ❑ Never ❑ 1-4 month ❑ 1-3 week ❑ 4+ per week

Have you used drugs recreationally or for non-medical reasons? ❑ Yes ❑ No
If yes, please list_____ Date of last use_____

Have you ever been verbally, emotionally, sexually or physically abused or threatened by your partner or anyone else?
❑ Yes ❑ No

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VIII. GYNECOLOGIC AND SEXUAL HISTORY:

Are you sexually active? ❑ Yes ❑ No

Is your sexual activity with: ❑ Men ❑ Women ❑ Both

Pain with intercourse? ❑ Yes ❑ No

Bleeding with intercourse? ❑ Yes ❑ No

Have you had a new sexual partner in the past year? ❑ Yes ❑ No

Menopausal ❑ Yes ❑ No Age ay menopause_____. Bleeding since menopause? ❑ Yes ❑ No

If menopausal, please skip to section IX (Family History)

Date of last menstrual period _____ #Days between period ❑ <25 ❑ 25-35 ❑ >35

#Days bleeding _____ Bleeding/Spotting between periods ❑ Yes ❑ No

Do you use birth control? ❑ Yes ❑ No *Please check all that apply:*

❑ Condoms	❑ Withdrawal / "pull out"	❑ Rhythm / natural method	❑ Pill
❑ NuvaRing	❑ Nexplanon implant	❑ Patch	❑ DepoProvera
❑ IUD	❑ Tubes tied	❑ Vasectomy	❑ Other _____

IX. FAMILY HISTORY

Have any immediate family members (father, mother, child, grandparents, siblings) been diagnosed with new medical problems:_____

Family Cancer History: ❑ No changes from previous year

Please consider close blood relatives: You, parents, siblings, half-siblings, children, grandparents, grandchildren, aunts/uncles, first cousins.

	You—Age of your diagnosis	Parents /Siblings/ Children	Age of diagnosis	Relatives on mother's side	Age of diagnosis	Relatives on father's side	Age of diagnosis
Example: Breast cancer		*Mother*	*57*			*Aunt*	*62*
Breast cancer (male or female)							
Ovarian cancer							
Uterine cancer							
Colon/rectal cancer							
Other cancers (specify type—thyroid, prostate, melanoma, stomach, pancreatic, bowel, kidney, bladder)							
❑ Yes ❑ No Are you of Ashkenazi Jewish descent?							
❑ Yes ❑ No Have you or anyone in your family had gentic testing for hereditary cancer syndrome?							

Are there specific issues you would like to discuss with your provider today? _____

_____