

# WOMEN'S HEALTH CONSULTANTS, PA

## INFORMATION UPDATE

Name: \_\_\_\_\_  
Date: \_\_\_\_\_  
Age: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_  
Work Phone #: \_\_\_\_\_

**So that we may provide the best medical care to you, please help us by completing this questionnaire. If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.**

What is the reason for your visit today? \_\_\_\_\_  
Do you have any questions, problems or concerns that you would like to discuss with us today? \_\_\_\_\_

**Since your last visit** have you had any serious illnesses, operations or injuries? If so, what is/are the name(s) of the physician(s) that you have seen? \_\_\_\_\_

Please list any **prescription medications** that you are taking with their doses. \_\_\_\_\_

Are there any other physicians/healthcare providers that you see? \_\_\_\_\_

Do you take **over-the-counter medications** / herbal supplements / vitamins or nutritional supplements? Please list: \_\_\_\_\_

What is the date of your **last menstrual period**? \_\_\_\_\_ Have your periods changed? \_\_\_\_\_  
How? \_\_\_\_\_

Are you currently sexually active? \_\_\_\_\_ Do you use a method of birth control? \_\_\_\_\_ Please circle the type used:  
B.C. pills/patch/ring diaphragm condoms spermicide IUD sponge natural/rhythm vasectomy tubal ligation  
Are you satisfied with this method of birth control? \_\_\_\_\_ Do you want any information about birth control? \_\_\_\_\_  
Please list the method about which you would like more information: \_\_\_\_\_  
Do you have any questions about safer sex? \_\_\_\_\_ About sexuality? \_\_\_\_\_  
When was your last Pap smear? \_\_\_\_\_

Have you changed any habits (smoking, drinking or drug use) or occupation since your last visit? \_\_\_\_\_

Do you have any current stress in your life? \_\_\_\_\_

Have there been any changes in your relationship with your husband, partner or boyfriend? \_\_\_\_\_

Do you exercise? \_\_\_\_\_ How often? \_\_\_\_\_ What type? \_\_\_\_\_

If you have had one, when was your last **mammogram**? \_\_\_\_\_

If you are over 49, have you had colon cancer screening? \_\_\_\_\_ (Please circle all that apply and date)  
Stool test \_\_\_\_\_ Flexible sigmoidoscopy \_\_\_\_\_ Colonoscopy \_\_\_\_\_

Have you discovered any additional information about your family history that we should know? \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Safety Update**

Do you usually wear seat belts? \_\_\_ No \_\_\_ Yes    Do you wear safety helmets for at-risk sports? \_\_\_ No \_\_\_ Yes  
Do you have any guns in your home? \_\_\_ No \_\_\_ Yes    Do you use sunscreen and sunglasses? \_\_\_ No \_\_\_ Yes  
Do you smoke cigarettes? \_\_\_ No \_\_\_ Yes    Packs per day: \_\_\_    How many years? \_\_\_  
Do you drink alcohol? \_\_\_ No \_\_\_ Yes    Drinks per day or week: \_\_\_  
Do you use marijuana, cocaine or other street drugs? \_\_\_ No \_\_\_ Yes  
Do you have any relationships in which you feel unsafe? \_\_\_ No \_\_\_ Yes

**Please circle any of the following symptoms that you may currently be experiencing.**

**Constitutional:**

Fever  
Chills  
Sweats  
Weight change - gain or loss  
Weakness  
Fatigue

**Eyes:**

Change in vision, dry eyes

**Ears, Nose, Mouth, Throat:**

Change in hearing  
Nose bleeds  
Sore throat  
Dry mouth

**Cardiovascular:**

Dizziness  
Shortness of breath  
Chest pain  
Loss of consciousness  
Palpitations

**Respiratory:**

Chest pain  
Cough - productive or dry  
Shortness of breath  
Wheezing

**Gastrointestinal:**

Abdominal pain  
Nausea, vomiting  
Change in bowel habits  
Change in appetite  
Dark or bloody stool  
Indigestion  
Constipation or diarrhea

**Hematologic/Lymphatic:**

Swollen lymph glands  
Easy bruisability

**Gynecological:**

Bleeding or pain with intercourse  
Unusual vaginal discharge or odor  
Vulvar or vaginal itching or burning  
Pelvic pain/Libido change

**Urinary:**

Painful urination  
Frequent urination  
Urinary urgency  
Blood in urine  
Urinary incontinence  
Getting up at night to urinate

**Musculoskeletal:**

Back pain  
Weakness  
Joint pain, stiffness, swelling

**Skin/Breast:**

Nodules  
Changes in moles, freckles  
Change in hair - growth, loss, texture  
Breast lumps  
Breast nipple discharge  
Breast pain

**Neurological/Psychiatric:**

Memory change  
Depression/Anxiety  
Mood swings  
Numbness or tingling  
Migraines/headaches

**Endocrine:**

Weight change  
Excessive thirst, urination  
Tremor  
Cold or heat intolerance

**Nutritional Update:**

Classify your diet (Please circle):  
Average, high fat, low fat, carnivore, vegetarian,  
vegan, special diet (ie, Atkins, Weight Watchers)

Calcium source and amount:

Vegetable servings per day:

Fruit servings per day:

Protein source and amount per day:

Caffeine intake per day:

**Thank you for taking the time to answer these questions. Most insurance companies now require this information to be updated at every visit.**

Reviewed \_\_\_\_\_