Riverview Women's Health

Female Patient Information Form

In order to learn about your general state of health, we would ask that you take a few minutes to complete the following questionnaire before seeing your health care professional. This will allow the provider to spend more time focusing on your condition or problem, answering your questions and discussing your treatment options.

Patient Name:______________________________Date of Birth:_________Age:____

Date:___________ Preferred Name:__________________

Please list all Current Medications (Including any Contraception, Vitamins, Supplements):

List Known Allergies:

Medical Conditions (Past or Present) :

____Diabetes	____Fibroids	____Thyroid Disease
____High Blood Pressure	____Colitis/Diverticulosis	____Sexually Transmitted Disease
____Stroke	____Cholesterol	____Hepatitis/Liver Disease
____Anemia	____Migraine Headaches	____Heart Disease
____Clotting Disorder	____Kidney Disease/Kidney Stones	____Asthma
____Abnormal Pap Smear	____Eating Disorder	____Autoimmune Disorder
____Endometriosis	____Breast Problems	____Arthritis
____Polycystic Ovarian Syndrome	____Lung Problems	____Osteoporosis
___Anxiety/Depression	____Cancer	____Hormone Therapy
___Gallbladder/Gallstones	____Seizure Disorder	____Other

Gynecological History:

Date and Result of: Last Pap Smear______________ ___Mammography __________ ____BoneDexa _________

Colonoscopy ______________Pelvic Ultrasound _____________ __Bloodwork______________Last Physical Exam___________

Gardasil/ HPV Vaccination: Yes/ No Annual Flu Shot: Yes/ No TDAP/ Tetanus Vaccination in last ten years: Yes/ No

Menstruation: Age of Onset______Last Menstrual Period__________Time Between Periods_________Duration__________

Flow: Regular______Irregular_____Heavy____Moderate_____Light_____

Have you gone through menopause : Yes/ No If yes, what year or age:_____Currently having menopausal symptoms:Yes/No

Have you ever had an infection of reproductive organs: Yes/ No

Do you have bleeding during/after intercourse: Yes/ No

Current abnormal breast symptoms: Yes/ No

Current abnormal vaginal/urinary symptoms: Yes/ No

Present Contraception: (Please circle ALL that apply) Pills Intrauterine Device(IUD) Injection Condoms Nuvaring Tubal Ligation Vasectomy Subdermal Implant(Arm) Patch Other

Social History:

Alcohol	Yes / No	Minimal / Moderate / Heavy
Smoker	Yes / No	Minimal / Moderate / Heavy
Caffeine	Yes / No	Minimal / Moderate / Heavy
Street Drug/Illicit Drug	Yes / No	Minimal / Moderate / Heavy

Pregnancy History:

Total Pregnancies___ _Full Term____Premature____Miscarriage__ _Termination/Abortion____Ectopic___

Infertility: Yes / No   How long have you been attempting pregnancy?__________________

In Date Order, Please List ALL Pregnancies (Including Miscarriage/Termination/Ectopic):

Date	Type of Delivery	Sex	Birth Weight	Doctor and Hospital	Complications

Surgical History:

In Date Order, Please List ALL Surgeries with Date/Year(Including any Non-Gynecological, Breast or Gynecological) :

Hospital History:

In Date Order, Please List ALL Non-Surgical Hospitalizations with Date/Year:

Family History:

Patient Adopted: Yes/ No

Relative	Alive	If Deceased, Age	Major Illness(I.E. Cancer, Diabetes, Heart disease, HTN) /Cause of Death
Mother	Yes / No		
Father	Yes / No		
Sister(s)	Yes / No		
Brother(s)	Yes / No		
Son(s)	Yes / No		
Daughter(s)	Yes / No		

Family Cancer History:

Cancer	Relationship	Maternal/Paternal	If Deceased, Age
Breast			
Ovarian			
Colon			
Uterine			
Cervical			
Pancreatic			
Other			