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Initial review
Other reviews
Account:

ALABAMA WOMEN'S HEALTH CARE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*:	**Family Doctor:**	**Today's Date**:

☐ **Pre-Menopausal**			☐ **Post-Menopausal**		
LMP:	____ **days bleeding**	☐ light ☐ heavy	**Date of menopause**:	**Age:**	Have you taken hormones? ☐ yes ☐ n number of years _______
contraceptive:			Are you currently taking hormones? ☐ yes ☐ no Name of hormone drug ____		

PERSONAL HEALTH HISTORY

SCREENING TESTS	☐ **PAP** **Date** _____________	☐ **MAMMOGRAM** **Date** _______________	☐ **BMD** **Date** _______________

Do you have a vaginal discharge? ☐ yes ☐ no	how long?	What color is it?	__ burning or itching	Could you have been exposed to a sexually transmitted disease?
	When was your last vaginal infection?		What kind of infection was it?	

Do you have pelvic pain?	☐ yes ☐ no	Describe:
Do you have any abnormal bleeding?	yes ☐ no	Describe:
Do you have burning or pain when emptying your bladder?	☐ yes ☐ no	Describe:

MEDICAL HISTORY

Year	**Illness**
	Additional space on back

SURGICAL HISTORY

Year	**Type of Surgery**
	Additional space on back

MEDICATION

List your prescribed drug and over-the-counter drugs, such as vitamins and inhalers

PREGNANCIES

Date		
	☐ Vaginal delivery	☐ Cesarean section
	☐ Vaginal delivery	☐ Cesarean section
	☐ Vaginal delivery	☐ Cesarean section
	☐ Vaginal delivery	☐ Cesarean section

ALLERGIES

List any allergies to medications, food, and environment

Name the Drug or other	**Reaction You Had**

SOCIAL HISTORY		FAMILY HISTORY	
Where do you work?		**Relation**	**Illness**
Occupation?		Father	
Who lives in your household?		Mother	
Do you smoke?	Packs/day____________	Children	
Do you drink alcohol?	Weekly amount __________	other	

Review of System

Check all symptoms you have NOW

General	Head/Neck	Heart	Lungs	Gastro/intestinal
☐ Excessive fatigue	☐ Frequent headaches	☐ High blood pressure	☐ Shortness of breath	☐ Heartburn
☐ insomnia	☐ Frequent colds	☐ Chest pain	☐ Wheezing	☐ Vomiting
☐ Weight gain	☐ Swelling in neck	☐ Irregular heart beat	☐ Chronic cough	☐ Constipation
☐ Weight loss	☐ migraine	☐ murmur	☐ asthma	☐ Diarrhea
☐ Recent infections	☐	☐	☐ Exposure to TB	☐ Blood in BM
Urinary Tract	**Muscles/Joints**	**Neurological**	**Skin**	**Female**
☐ Unintentional loss of urine	☐ Bone/joint pain	☐ PMS	☐ Rash	☐ Lump in breast
☐ Blood in urine	☐ Back pain	☐ Menopause symptoms	☐ Cysts/tumor	☐ Breast pain
☐ Urine retention	☐ Arthritis	☐ Depression	☐ Unusual mole	☐ Breast soreness
☐ Waking to urinate	☐ Difficulty moving arms/legs	☐ Personality changes	☐ Bruising	☐ Night sweats
☐ Urine frequency	☐ Muscle pain	☐ Psychotherapy/counseling	☐	☐ Heavy bleeding
☐	☐	☐	☐	☐ Low libido
☐	☐	☐	☐	☐ Vaginal dryness

List additional information in the space below:

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Signature: ______________________________ **Date**: __________________________________