COLLEYVILLE FAMILY MEDICINE

Baylor Family Health Center

Name: _____ Today's Date: _____ Age: _____

You are here for a Well Woman Physical……Please answer the following:

1. Date of your last menstrual period: _____ Date of last PAP smear: _____
   Have you ever had an abnormal PAP? YES / NO When? _____
   What was wrong and what was the treatment? _____
   Date of last mammogram: _____/_____/_____ How many pregnancies? _____ How many living children? _____
   Have you had a hysterectomy? YES / NO Why? _____
   Were both of your ovaries removed? YES / NO
   Are you taking estrogen or hormone replacement therapy (ERT) or (HRT)? YES / NO
   If yes, what type and dosage? _____
2. Have there been any changes in your periods? YES / NO
   If yes, please explain: _____
3. Have you ever been diagnosed with: (if checked, give date)

O Yeast Infection ___/___/___	O Bacterial vaginosis ___/___/___	O Trichomoniasis ___/___/___
O Gonorrhea ___/___/___	O Chlamydia ___/___/___	O Syphilis ___/___/___
O Genital Warts ___/___/___	O HIV (AIDS) ___/___/___	O Herpes ___/___/___
O Breast Cancer ___/___/___	O Cervical Cancer ___/___/___	O Uterine Cancer ___/___/___

4. Have you recently had an unusual vaginal discharge? YES / NO
   Does it itch? YES / NO
   Does the discharge have an odor? YES / NO
5. Your current method of birth control: _____
6. Do you ever douche? YES / NO If yes, how often? _____
   (Studies show this is detrimental to your vaginal health)
7. Have you ever had vaginal intercourse (sex)? YES / NO
8. Are you sexually active now? YES / NO
   If yes, was your last partner male or female? MALE / FEMALE
   How long have you been with your partner? _____
   How many sexual partners have you had in your lifetime? _____
   (The # of sexual partners is important to the doctor because it can increase risk for cancer and/or other diseases)
9. Life Style: If yes:
   Do you Smoke? YES / NO How much? _____
   Do you drink alcohol? YES / NO How much? _____
   Do you use street drugs? YES / NO What type/How often? _____
10. Do you do monthly self breast exams? YES / NO
    If no, why? _____
11. Is there a family history of breast, uterine, or ovarian cancer? YES / NO
    If so, who? _____
12. Do you currently take Calcium Supplements? YES / NO If yes, how much per day? _____
13. Have you been screened for osteoporosis (loss of bone density)? YES / NO When? _____
14. If you are 50 or older, have you had a flexible sigmoidoscopy or colonoscopy in the last 5 years? YES / NO
    Result: _____
15. Are you on any "natural" supplements? YES / NO

NAME: _____ **DOB**: ____/____/_____

PAST MEDICAL HISTORY: (***Please check if you have had any of the following conditions***)

	Year		*Year*		*Year*
☐ Cancer	_____	☐ Hypothyroidism	_____	☐ High Cholesterol	_____
☐ High Blood Pressure	_____	☐ Diabetes	_____	☐ Asthma	_____
☐ Arthritis	_____	☐ GERD	_____	☐ Migraine Headache	_____
☐ Stroke	_____	☐ Heart Attack	_____	☐ Depression	_____
☐ Skin Cancer	_____	☐ Osteoporosis	_____	☐ Anxiety	_____
☐ Hepatitis	_____	☐ Blood Clots	_____		
				☐ Congestive Heart Failure	_____
				☐ Sexually Transmitted Disease	_____

Other medical problems not listed above (Please list here): _____

_____

PREVIOUS SURGERY AND / OR HOSPITALIZATION: (***Please list here***)

Surgery / Reason	***Hospital***	***Doctor***	***Year***
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY: *Please indicate below any family members with a history of: Tuberculosis, Diabetes, Heart Disease, Cancer (type), Emphysema, Kidney Disease, Asthma, Bleeding Tendencies, Anemia, Seizure Disorders, Glaucoma, High Blood Pressure, Gout, Arthritis, Ulcers, Stroke, Anxiety or Depressive Disorders.* Please include any disorders not listed above.

Father: _____
Mother: _____
Grandparents: _____
Siblings: _____
Children: _____

SOCIAL HISTORY:

☐ Married ☐ Divorced ☐ Widowed ☐ Single

Occupation (current or previous if retired): _____ Recent change: ☐ Yes ☐ No

Current Tobacco Use: ☐ Yes ☐ No
Year Started: _____ Year Quit: _____
Type: _____ Daily Amount: _____

Alcohol Use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

FEMALES ONLY

Last Menstrual Period: _____ Age at Onset of Periods: _____
Duration of Periods: _____ Interval Between Periods: _____ ☐ Regular ☐ Irregular
Heavy Periods: ☐ Yes ☐ No Present Birth Control Method: _____
Number of Pregnancies: _____ Number of Miscarriages: _____ Number of Abortions: _____