Women's Primary Care
Women's Medicine Collaborative - a Lifespan partner
146 West River St. ~ 3rd Floor ~ Suite 11-D
Providence, RI 02904

PLEASE FILL OUT ALL FORMS AND BRING TO APPOINTMENT
Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name: ____________________________ First:____________________________ DOB: _________________

Other Physicians
Obstetrician/Gynecologist _______________________ Endocrinologist ___________________________________
Gastroenterologist______________________________ Other ____
Dermatologist__________________________________ ____

Screening and Prevention
Date of Last Physical Exam: ________________________ Physician: _________________________________

Last Cholesterol test?	Date_____	☐ Normal	☐ Abnormal	Please check all immunizations that are up to date:
Colonoscopy ?	Date_____	☐ Normal	☐ Abnormal	☐ measles ☐ mumps ☐ rubella
Mammogram ?	Date_____	☐ Normal	☐ Abnormal	☐ Hepatitis B ☐ tetanus (date________)
Pap Smear?	Date_____	☐ Normal	☐ Abnormal	☐ PPD (date__________)
Bone Density ?	Date_____	☐ Normal	☐ Abnormal	☐ pneumonia shot (date__________)
Stress Test?	Date_____	☐ Normal	☐ Abnormal	☐ flu shot (date__________)

HIV screening is now recommended for all individuals. Have you ever been tested for HIV? ☐ Yes ☐ No

Past Medical History (please check all that apply) ☐ High Blood Pressure ☐ Diabetes (including gestational)

☐ Stroke	☐ High cholesterol	☐ Heart Attack	☐ Asthma	☐ Pneumonia
☐ Emphysema	☐ Tuberculosis	☐ Kidney Disease	☐ Thyroid Disease	☐ Ulcers
☐ Liver Disease	☐ Alcohol problems	☐ Depression	☐ Anxiety	☐ Migraine
☐ Arthritis	☐ Osteoporosis	☐ Fractures	☐ Bleeding Tendency	☐ Anemia
☐ Blood clot	☐ Seizure	☐ frequent UTI	☐ Sexually transmitted disease	
☐ Ovarian cysts	☐ Fibroids	☐ D.E.S. exposure		

☐ Cancer: type______________________________ ☐ Other ____

Prior Hospitalizations/Surgeries:
____
____
____

Have you ever received a blood transfusion? ☐ Yes ☐ No If yes, year _________________________________
Have you had a hysterectomy? ☐ Yes ☐ No If yes, reason__________________________________
Were your ovaries removed? ☐ Yes (1) ☐ Yes (2) ☐ No

List all MEDICATIONS (please include non-prescription drugs)	**Dose**	**Frequency**

List all ALLERGIES: Medication/Food	**Reaction**

Family History		**AGE**	**Condition**	**Age at Death**	**Cause**
Father	______	______	______	______	______
Mother	______	______	______	______	______
Brothers/Sisters	1. ______	______	______	______	______
	2. ______	______	______	______	______
	3. ______	______	______	______	______
	4. ______	______	______	______	______

Do you know of any blood relative who has or had: □ Diabetes □ Heart Attack □ High Blood Pressure
□ Stroke or Blood Clot □ Tuberculosis □ Asthma □ Thyroid Disease □ Kidney Disease
□ Liver Disease □ Cancer: Type__________ □ Depression □ Alcoholism □ Bleeding disorder

Lifestyle and Personal Habits

Who do you live with at home? ______________________ Your occupation________________________________
Do you/have you ever smoked? □ Yes □ No If yes, _____ packs/day for _____yrs Quit date ________
Do you drink alcohol? □ Yes □ No If yes, number of drinks/week ______________________
Do you use any recreational drugs? □ Yes □ No If yes, what type? ______________________________
Do you exercise regularly? □ Yes □ No Activity: _______________ hours/week_____________
Do you follow a special diet? □ low fat □ low carb □ vegetarian □ other ___________________________
How many meals/day do you have? __________________ Servings of calcium per day? ______________________
Do you wear seatbelts? □ Yes □ No Do you feel safe at home at present? □ Yes □ No
Do you have smoke alarms at home? □ Yes □ No Has anyone ever physically hurt or threatened you? □ Yes □ No
Do you have guns in your home? □ Yes □ No Has anyone ever hit, kicked, or choked you? □ Yes □ No
Has anyone ever forced you to have sexual activity? □ Yes □ No

OB/GYN HISTORY: Number of Pregnancies: _______ Living: _______ Miscarriages: _______ Abortions: ______
Are you currently sexually active? □Yes □ No Do you partner with □ Men □ Women □ Both
Do you use contraception? □ birth control pills □ contraceptive ring □ contraceptive patch □ condoms □ IUD
□ tubal ligation/vasectomy □ diaphragm □ other ____________________________
Planning a pregnancy in the next year? □Yes □ No Last Menstrual Period :_________________
Age at first period:______ Occurs every ____ days Length of flow: ____ days Age at Menopause:________
History of infections (please check all that apply): □ herpes □ gonorrhea □ chlamydia
□ syphilis □ PID □ warts □ yeast □ trichomonas □ gardnerella
Have you had an abnormal PAP in the past? □ Yes □ No

Review of Systems Height _________________ Weight _________________

General:	□ problems sleeping	□ fevers	□ night sweats	□ appetite change	
Eyes:	□ glasses/contact lens	□ glaucoma	□ double vision	□ last eye exam_____________	
Ears/Nose/Throat:	□ hearing loss	□ nosebleeds	□ sinus trouble	□ last dental exam______________	
Neck:	□ swollen glands	□ pain	□ lump in neck		
Breasts:	□ pain □ lumps	□ nipple discharge			
Respiratory:	□ shortness of breath	□ wheezing	□ cough	□ coughing up blood	
Cardiac:	□ chest pain	□ palpitations	□ heart murmur	□ swelling in legs	
Gastrointestinal:	□ abdominal pain	□ constipation	□ diarrhea	□ bloating/gas	□ rectal bleeding
Genitourinary:	□ frequent urination	□ painful urination	□ blood in urine	□ frequent urination at night	
	□ irregular bleeding	□ vaginal dryness	□ painful intercourse		
Musculoskeletal:	□ joint pain/stiffness	□ muscle aches	□ back pain	□ leg cramps with walking	
Skin:	□ varicose veins	□ moles changing	□ rash	Do you wear sunscreen? □ Yes □ No	
Neurological:	□ numbness/tingling	□ tremor	□ weakness	□ memory changes	□ headaches
Emotional Health:	□ depression	□ anxiety	□ family issues	□ eating disorders	
Hematologic:	□ easy bruising	□ blood clot	□ anemia	□ excessive bleeding	
Endocrine:	□ increased hunger	□ feeling cold/hot	□ hot flashes	□ weight gain/loss __________lbs.	

Date ________________________________ Signature____