Women's Wellness & Cosmetic Laser Center of Loudoun

excellence in women's healthcare

Welcome to our practice. The information on this form is intended to help the physician with your diagnosis and treatment. Please complete both sides of the form as fully as possible.

Name_____ Date_____

Primary Care Physician_____ Age_____ Birth Date_____

Marital Status: S M Sep W D SSP (same sex partner)

FAMILY HISTORY:

Has anyone in your family had the following: Include Mother (M), Father (F), Brother (B), Sister (S) Grandfather (MGF or PGF - Maternal or Paternal), Grandmother (MGM or PGM- Maternal or Paternal), Aunt (A), Uncle (U):

No	Yes	Who		No	Yes	Who		No	Yes	Who	
❑	❑	_____	Diabetes	❑	❑	_____	High blood pressure	❑	❑	_____	Sickle cell disease
❑	❑	_____	Heart attack	❑	❑	_____	Stroke	❑	❑	_____	Birth defects/hereditary disease
❑	❑	_____	Cancer	❑	❑	_____	Blood clots (leg / lung)	❑	❑	_____	Osteoporosis
❑	❑	_____	Tuberculosis	❑	❑	_____	Thyroid disease	❑	❑	_____	Other_____

MEDICAL HISTORY: Do you have, or have you ever had, any of the following:

No	Yes	Now		No	Yes	Now		No	Yes	Now	
❑	❑	❑	Sickle cell trait or disease	❑	❑	❑	Diabetes	❑	❑	❑	Kidney problem
❑	❑	❑	Heart disease	❑	❑	❑	Thyroid problem	❑	❑	❑	Recurrent bladder infection (>3 per year)
❑	❑	❑	Heart murmur	❑	❑	❑	Severe depression	❑	❑	❑	IBS
❑	❑	❑	Do you take antibiotics for dental work?	❑	❑	❑	Psychiatric problems	❑	❑	❑	GERD (reflux)
❑	❑	❑	High blood pressure	❑	❑	❑	Numbness or tingling of extremities	❑	❑	❑	Colitis
❑	❑	❑	Varicose veins/phlebitis	❑	❑	❑	Epilepsy/seizures	❑	❑	❑	Liver disease/jaundice
❑	❑	❑	Blood clots (legs/ lungs)	❑	❑	❑	Stroke	❑	❑	❑	Hepatitis
❑	❑	❑	Bleeding disorder	❑	❑	❑	Frequent headaches	❑	❑	❑	Mononucleosis
❑	❑	❑	High cholesterol,	❑	❑	❑	Migraine headaches	❑	❑	❑	Asthma
❑	❑	❑	Positive tuberculosis test (PPD)	❑	❑	❑	Rubella infection or immunization (German measles)	❑	❑	❑	Gall bladder problem
❑	❑	❑	HIV exposure					❑	❑	❑	Any other illness (please list)
❑	❑	❑	Cancer	❑	❑	❑	Chicken pox or immunization				
❑	❑	❑	Breast disease								

_____

_____

Date of last tetanus shot (month/year)_____

MEDICATIONS

List all medications you are using by name and dosage (include vitamins, calcium and herbs)

_____

_____

_____

_____

_____

_____

ALLERGIES

❑ No known allergies to medications

Allergies to medications: Please list name of drug and reaction:

_____

_____

Are you allergic to: Copper ❑ Yes ❑ No

Rubber/latex ❑ Yes ❑ No

Iodine or shellfish ❑ Yes ❑ No

SURGICAL/HOSPITALIZATION HISTORY

Please list the date and type of surgery or reason for hospitalization:

Date	Type	Date	Type
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MENSTRUAL HISTORY

Age period started_____ Date of last period_____

Periods come every _____ days and last for _____days. Periods are ❑ regular ❑ irregular ❑ light ❑ moderate ❑ heavy.

Do you have cramps with your period? ❑ No ❑ Yes If yes, what do you do for the discomfort_____

Do you bleed between periods? ❑ No ❑ Yes Do you ever use tampons? ❑ No ❑ Yes

GYN HISTORY

Date of last Pap smear_____ Date of last mammogram_____ Date of last DEXA Scan_____

No	Yes	Now		No	Yes	Now	
❑	❑	❑	Vaginal discharge/infection	❑	❑	❑	Abnormalities of the uterus
❑	❑	❑	Unusual vaginal bleeding	❑	❑	❑	Tumors/cysts of ovaries
❑	❑	❑	DES exposure (did your mother take DES?)	❑	❑	❑	Pain/bleeding with intercourse
❑	❑	❑	STD (sexually transmitted disease):	❑	❑	❑	Abnormal Pap smear - describe_____
			❑ syphilis ❑ gonorrhea ❑ trichomonas	❑	❑	❑	Cervical lesions/biopsy/cryotherapy/Letz cone
			❑ chlamydia ❑ herpes ❑ genital warts ❑ HIV	❑	❑	❑	Premenstrual symptoms (mood changes, water retention, headaches, etc.)

(PLEASE TURN PAGE OVER)

Patient Name_____ Today's Date_____

PREGNANCY HISTORY

Age of first pregnancy_____ ❑ Never been pregnant Have you ever had difficulty becoming pregnant? ❑ No ❑ Yes ❑ N/A

List number of: Pregnancies_____ Living children_____ Abortions_____ Miscarriages_____

Date of Pregnancies (date of delivery or termination)	Type of Delivery (Vaginal/C-section/VBAC/Termination/Miscarriage)	Sex

CONTRACEPTION

Total number of sexual partners in your lifetime_____

Age of first intercourse_____ Are you sexually active at present? ❑ No ❑ Yes Do you currently have a female partner? ❑ No ❑ Yes

If you have ever used birth control, please list all methods used in the past:

Birth control method	Date(s) of use	Any problems with this method (yes/no)

Present method_____ Used since_____ Any problems (yes/no)_____

SOCIAL/PERSONAL HISTORY

Highest year of school completed: 7 8 9 10 11 12 13 14 15 16 17 >17 Degree_____ City/Country of Birth_____

Occupation_____ Employer_____

Present weight is: ❑ Satisfactory ❑ Unsatisfactory Present weight is: ❑ About the same as a year ago ❑ More ❑ Less

Caffeine: Average #cups coffee/day _____ tea_____ caffeinated soda_____

Calcium: ❑ No ❑ Yes # servings/day (milk, cottage cheese, ice cream, yogurt)_____

Tobacco use: ❑ Never ❑ Quit (when)_____ ❑ Currently smoke _____packs/day for how many years_____

Marijuana use: ❑ No ❑ Yes Other street drugs: ❑ No ❑ Yes

What?_____

Do you feel you have a problem? ❑ No ❑ Yes

Alcohol: # drinks per week (beer, wine, liquor) _____ Do you feel you have a drinking problem? ❑ No ❑ Yes

How many drinks does it take to feel an effect?_____ Has anyone ever told you that you drink too much? ❑ No ❑ Yes

Have you ever been in treatment for alcohol problems? ❑ No ❑ Yes

What do you do for exercise?

Type/Frequency:_____ Have you been exposed to toxic substances? ❑ No ❑ Yes If so, what_____

Have you ever been physically, sexually, or emotionally abused? ❑ No ❑ Yes

Do you perform monthly breast self exams (BSE)? ❑ No ❑ Yes Do you use seat belts ❑ No ❑ Yes

Are you interested in HIV (AIDS) testing? ❑ No ❑ Yes

Sex: what questions do you have?_____

What concerns do you have to discuss with your health provider?_____

REVIEW OF SYSTEMS

Have you experienced any of the following within the last year? Please indicate NO, YES or NOW below.

No	Yes	Now	
			CONSTITUTIONAL
❑	❑	❑	Weight gain/loss > 10lbs.
❑	❑	❑	Marked fatigue
❑	❑	❑	Unexplained night fever/sweats
❑	❑	❑	Migraine headaches
			EARS/NOSE/MOUTH/THROAT
❑	❑	❑	Hearing loss
❑	❑	❑	Chronic sinus problems
❑	❑	❑	Nose bleeds
			CARDIOVASCULAR
❑	❑	❑	Heart trouble
❑	❑	❑	Chest pain/angina pectoris
❑	❑	❑	Palpitations
❑	❑	❑	Swelling of feet or ankles
			HEMATOLOGIC/LYMPHATIC
❑	❑	❑	Bruising tendency/bleeding disorder
❑	❑	❑	Anemia
❑	❑	❑	Varicose veins, blood clots, phlebitis
❑	❑	❑	Blood transfusion in last year
❑	❑	❑	Persistent enlarged glands
			GASTROINTESTINAL
❑	❑	❑	Difficulty swallowing
❑	❑	❑	Frequent diarrhea/constipation
❑	❑	❑	Stomach ulcers

No Yes Now

PSYCHIATRIC

❑ ❑ ❑ Depression

❑ ❑ ❑ Anxiety disorder

MUSCULOSKELETAL

❑ ❑ ❑ Joint stiffness/swelling

❑ ❑ ❑ Weakness in muscles or joints

❑ ❑ ❑ Back pain

NEUROLOGICAL

❑ ❑ ❑ Lightheadedness or dizziness

❑ ❑ ❑ Numbness or tingling of extremities

❑ ❑ ❑ Tremors

❑ ❑ ❑ Stroke/paralysis

❑ ❑ ❑ Head injury/concussion

RESPIRATORY

❑ ❑ ❑ Chronic or frequent cough

❑ ❑ ❑ Spitting up blood

❑ ❑ ❑ Shortness of breath

❑ ❑ ❑ Asthma

INTEGUMENTARY (skin, breast)

❑ ❑ ❑ Rash or itching

❑ ❑ ❑ Change in skin color/hair/nails

❑ ❑ ❑ Breast pain/lump/discharge