WOODWARD & ASSOCIATES, P.C.

Initial Patient History

NAME: _____ ***BIRTH DATE:*** _____ ***SS#:*** _____

ADDRESS: _____ ***CITY:*** _____ ***STATE:*** _____ ***ZIP:*** _____

HOME PHONE: _____ ***WORK PHONE:*** _____ ***CELL PHONE:*** _____

EMAIL ADDRESS: _____

Occupation: _____ *Referred By:* _____

Spouse's Name: _____ *Spouse's Occupation:* _____

Date of Last Period: _____ *Date of Period prior to that:* _____ *Age of first menses:* _____

Are periods regular? (please circle) ***Yes/No*** *How often do they occur?* _____
How long are periods? _____ *days* *Flow: (please circle)* ***Light/Medium/Heavy*** *Cramping w/menses?* ***Yes/No***

Number of pregnancies: _____ *Number of living children:* _____ *Stillbirths:* _____
Number of tubal pregnancies: _____ *Number of miscarriages:* _____ *Neonatal deaths:* _____

Are you having any of the following? (please circle all that apply)
Vaginal discharge *External irritation* *Bleeding between periods* *Bleeding after intercourse*
Bowel problems _____ *Headaches* *Premenstrual irritability*
Bladder problems: cystitis, leakage, Other _____ *Menopausal symptoms (hot flashes, etc.)*
Do you take hormones? ***Yes/No*** _____

Last pap smear (date) _____ ***Results:*** _____
Current contraceptive method: _____

Do you smoke? _____ *How much?* _____ ***Do you Drink Alcohol?*** _____ *How much?* _____

Are you having any problems with any of the following? (Please circle all that apply)
Head *Eye* *Ears* *Nose* *Throat* *Asthma* *Pneumonia*
Coughing *Heart Murmur* *High blood pressure* *Rheumatic fever* *Thyroid* *Kidney Stones*
Kidney infections *Skin* *Bones* *Joints* *Other hormonal problems* _____
Other medical problems: _____

Allergies/Medications/Past Surgical History
Are you allergic to any medications? If yes, which medications _____
Any allergies to other things? _____
Current medications: _____
Have you ever had surgery? ***Y/N*** *If yes, please list type & date* _____
_____

Does any immediate family member have: (Please circle all that apply)
Diabetes *High Blood Pressure* *Breast Cancer* *Ovarian Cancer* *Colon Cancer*
Osteoporosis *Heart Disease (please describe)* _____
Other: _____
Spouse's family history _____