WOODWARD & ASSOCIATES, P.C.

Patient Information

Name: _____ Date of Birth:_____

Occupation: _____ Place of Employment: _____

Marital Status: Married Single Divorced Widowed Separated

Spouse's name: _____ Spouse's Birth Date: _____

Family Doctor: _____ Referring Doctor: _____

Number of children and their ages: _____

Current medications you are taking. ***(Please provide dosage and how often they are taken)*** *: _____*

_____

_____

_____

Allergies: _____

Method of Birth Control: _____ ***Do you do self breast exams?*** *YES NO* ***Hysterectomy****? YES NO*

Date of last Mammography? _____ Date of last menstrual period? _____

Reason you are here today:

Family History: *(Please circle appropriate response)*

High Blood Pressure:	*Yes/No*	*Osteoporosis:*	*Yes/No*	*Breast Cancer:*	*Yes/No*	*Stroke:*	*Yes/No*
Heart Disease:	*Yes/No*	*Depression:*	*Yes/No*	*Ovarian Cancer:*	*Yes/No*		
Diabetes:	*Yes/No*	*Glaucoma:*	*Yes/No*	*Colon Cancer:*	*Yes/No*		

Review of Systems: *(Please* ***v*** *if you have any of the following problems)*

Constitutional		***Ears/Nose/Mouth***		***Cardiovascular***		***Kidney/Bladder***	
Fever	☐	*Pain*	☐	*Chest Pain*	☐	*Urgency/Frequency*	☐
Weight Loss	☐	*Mass*	☐	*Short of Breath*	☐	*Must wear a pad*	☐
		Hearing Loss	☐	*Palpitations*	☐	*Loss of urine w/cough*	☐
		Other _____	☐	*High Blood Pressure*	☐	*Frequency at night*	☐
				Other_____	☐	*Other_____*	☐

Respiratory		***GI***		***Hematological***		***Musculoskeletal***		***Emotional***	
Asthma	☐	*Bowel changes*	☐	*Anemia*	☐	*Joint pain*	☐	*Depression*	☐
Chronic cough	☐	*Diarrhea*	☐	*Blood Disease*	☐	*Weakness*	☐	*PMS*	☐
Bronchitis	☐	*Constipation*	☐	*Other_____*	☐	*Swelling*	☐		
Other_____	☐	*Other_____*	☐			*Other_____*	☐		

Neurological		***Skin***		***Social History***		***Endocrine***	
Weakness	☐	*Tumor*	☐	*Drugs*	☐	*Thyroid*	☐
Dizziness	☐	*Rash*	☐	*Alcohol*	☐	*Diabetes*	☐
Headache	☐	*Masses*	☐	*Tobacco*	☐		
Numbness	☐	*Other_____*	☐	*Ever received a blood transfusion?*	***Y/N***		
Other_____	☐			*Are you know to be HIV positive?*	***Y/N***		

How did you hear about our practice? (please circle)

Advertisement Friend or family member Insurance company Other_____