WOODWARD & ASSOCIATES, P.C

Patient Information

www.woodwardassociates.com

Name:	Date of Birth:

Marital Status: Single Married Divorced Widowed Separated Life Partner

Family Doctor:	Referring Doctor:

Reason for your visit today:

Review of Systems:

(Please circle all that apply)

Constitutional	Ears/Nose/Mouth	Cardiovascular	GU/Bladder
Fever Weight Loss	Pain Mass Hearing Loss Other:______	Chest Pain Short of Breath Palpitations High Blood Pressure Other:______	Urgency/Frequency Must wear a pad (leakage) Loss of Urine w/Cough Frequency at night Other______
Respiratory Asthma Chronic Cough Bronchitis Other:______	**GI** Bowel Changes Diarrhea Constipation Other:______	**Hematological** Anemia Blood Disease Other:______	**Musculoskeletal** Joint Pain Weakness Swelling Other:______
Emotional Depression Anxiety PMS Other:______	**Neurological** Weakness Dizziness Headache Numbness Other:______	**Skin** Tumor Rash Masses Other______	**Endocrine** Thyroid Diabetes

Social History	Breast	GYN
(Please list how much & how often) Drugs: **YES/NO** ______ Alcohol: **YES/NO** ______ Tobacco: **YES/NO** ______	Lumps Pain Swelling Nipple Discharge Other______	Pelvic pain Abnormal bleeding Mass/Cyst Irregular menses Other______

Have you ever received a blood transfusion? Yes/No

Are you known to be HIV positive? Yes/No

Do you do self breast exams? Yes/No

Have you had a Hysterectomy? Yes/No

Date of last Mammogram: ______

Family History

Please list any immediate family member(s) that have any of the following conditions

High Blood Pressure______	Heart Disease ______	Diabetes ______
Osteoporosis ______	Depression ______	Glaucoma ______
Breast Cancer ______	Ovarian Cancer ______	Colon Cancer ______
Stroke ______	Other: ______	

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

Internet Advertisement Facebook Friend/Family Member Other______

Signature:______ ***Date:***______