## BALLARD WOMEN'S HEALTH

PATIENT HISTORY WORKSHEET

NAME ______________________________ AGE __________ DATE ____________

REFERRED BY ______________________________ PHONE ____________________

**REASON FOR VISIT**

### GYNECOLOGIC HISTORY

Date of last menstrual period ______________ or Age at Menopause _______
Cycle Length _______ days from start to start Duration from _____to _____days
Periods are ❑Regular ❑Somewhat Regular ❑Completely Irregular
Are you sexually active? ❑No ❑Yes, with ❑Men ❑Women ❑Both
Date of Last PAP Smear _____________ Result ❑Normal ❑Other ____________________
Date of Last Mammogram ___________ Result ❑Normal ❑Other ____________________
Birth Control Method (if any) __________________ Hormone Therapy (if any) _________________
Have you had the HPV Vaccine (Gardasil)? YES/ NO , Boosters? 1 or 2

| DO YOU HAVE? | NO | YES | COMMENTS (include when & treatment) |
|---|---|---|---|
| Heavy Menstrual Bleeding | ❑ | ❑ | ____________ |
| Painful Periods | ❑ | ❑ | ____________ |
| Irregular Periods | ❑ | ❑ | ____________ |
| Bleeding between periods | ❑ | ❑ | ____________ |
| Pain with intercourse | ❑ | ❑ | ____________ |
| Premenstrual difficulties | ❑ | ❑ | ____________ |
| Leakage of urine | ❑ | ❑ | ____________ |

| HAVE YOU EVER HAD? | | | |
|---|---|---|---|
| An abnormal PAP Smear | ❑ | ❑ | ____________ |
| A Cone Biopsy | ❑ | ❑ | ____________ |
| Genital warts / HPV | ❑ | ❑ | ____________ |
| Genital Herpes (Type II) | ❑ | ❑ | ____________ |
| Other Sexually transmitted diseases (Gonorrhea, Chlamydia, Trichomonas, Syphilis, HIV) | ❑ | ❑ | ____________ |
| A Breast Biopsy or Surgery | ❑ | ❑ | ____________ |
| Uterine Fibroids | ❑ | ❑ | ____________ |
| A Gynecologic Cancer/Breast Cancer | ❑ | ❑ | ____________ |
| Endometriosis | ❑ | ❑ | ____________ |
| Sexual assault or injury | ❑ | ❑ | ____________ |
| Other Female Surgery or Procedures | ❑ | ❑ | ____________ |

**MEDICATIONS (include dosage)**

**ALLERGIES**

Occupation: ____________________
Life Stressors: ____________________
____________________

**General Medical History**

Have you ever had:

| | | | | | |
|---|---|---|---|---|---|
| High Blood Pressure | ❑No | ❑Yes | Blood Transfusion | ❑No | ❑Yes |
| High Cholesterol | ❑No | ❑Yes | Hepatitis | ❑No | ❑Yes |
| Heart Disease | ❑No | ❑Yes | Gallstones | ❑No | ❑Yes |
| Heart Murmur | ❑No | ❑Yes | Rectal Bleeding | ❑No | ❑Yes |
| Asthma | ❑No | ❑Yes | Frequent or Severe Headaches | ❑No | ❑Yes |
| Tuberculosis | ❑No | ❑Yes | Migraines | ❑No | ❑Yes |
| Diabetes | ❑No | ❑Yes | Depression | ❑No | ❑Yes |
| Thyroid Disease | ❑No | ❑Yes | Epilepsy / convulsions | ❑No | ❑Yes |
| Frequent Urinary Infections | ❑No | ❑Yes | Insomnia | ❑No | ❑Yes |
| Kidney Disease | ❑No | ❑Yes | Recurrent Night Sweats | ❑No | ❑Yes |
| Osteoporosis | ❑No | ❑Yes | Cancer | ❑No | ❑Yes |
| Anemia | ❑No | ❑Yes | Clotting/Bleeding Disorder | ❑No | ❑Yes |

Additional Comments:

**Obstetrical History** (List all pregnancies, including miscarriages, abortions, and ectopic pregnancies)

**Past Surgical History** (Include approximate dates of each surgery)

**Health Habits**

| | | | |
|---|---|---|---|
| Do you Smoke | ❑No | ❑Yes | _____packs/day |
| Drink Alcohol | ❑No | ❑Yes | _____drinks/wk |
| Use Drugs | ❑No | ❑Yes | _____________ |
| Recent Weight Change | ❑No | ❑Yes | _____________ |
| Exercise Regularly | ❑No | ❑Yes | |
| Do self breast exams | ❑No | ❑Yes | |

**Family History**

| | | |
|---|---|---|
| Breast Cancer | ❑No | ❑Yes |
| Ovarian Cancer | ❑No | ❑Yes |
| Diabetes | ❑No | ❑Yes |
| Heart Attack or Stroke | ❑No | ❑Yes |
| Colon Cancer | ❑No | ❑Yes |
| Osteoporosis | ❑No | ❑Yes |

**Additional Comments. Other issues you would like to discuss.**

**Medical Aesthetics**

- ❑ I would like to discuss Skin Resurfacing, Collagen Induction Therapy (CIT) with Dermapen
- ❑ I would like to discuss Botox/Dysport, Restylane
- ❑ I would like to discuss weight loss and Ideal Protein
- ❑ I would like to discuss skin care products