Fax 731-422-2277

Woman's Clinic, P.A.

Dedicated to women's health for over 60 years. Specializing in routine and high risk pregnancies, gynecologic surgery, laparoscopy, infertility, urinary incontinence, pelvic prolapse, and menopause.

Please complete entire form for our providers.

Date: _____ Name: _____ Age: _____ Date of Birth: _____

Reason for visit: ◯ Annual Visit, or ◯ Problem (Describe if problem visit) _____

Referred by: _____ Primary Care Doctor: _____

How did you hear of the Woman's Clinic, P.A.? ◯ Search engine ◯ Friend /Family ◯ Doctor Referral ◯ Other _____

CURRENT MEDICATIONS

Drug Name	Dosage	Reason for Medication	Prescribing Physician

YOUR PAST MEDICAL AND FAMILY HISTORY (List relationship)

Illness	You	Family Member	Illness	You	Family Member
Anemia			Hepatitis		
Anxiety / Depression			High Blood Pressure		
Arthritis			Irregular Heart Beat		
Blood clots in veins			Kidney Stone		
Blood transfusion			Lung Cancer		
Breast Cancer			Lupus		
Cervical Cancer			Osteopenia / Osteoporosis		
High Cholesterol			Ovarian Cancer		
Colon Cancer			Pneumonia		
Crohn's Disease			Sickle Cell Disease		
Diabetes			Stomach Cancer		
Emphysema / COPD			Stroke		
Endometriosis			Thyroid Disease		
Irritable Bowel Syndrome			Tuberculosis		
Fibrocystic Breast Disease			Ulcer		
Headaches			Ulcerative Colitis		
Heart Attack			Urinary Leakage		
Heart Disease			Uterine Cancer		
Heartburn					

What is your preferred Pharmacy? _____ Do you take any over-the-counter medication or herbs? ◯ Yes ◯ No

Are you taking any Hormone Replacements? ◯ Yes ◯ No Are you taking any Birth Control? ◯ Yes ◯ No

Are you allergic to any medication? _____

Are you allergic to Latex? ◯ Yes ◯ No Are you allergic to Shellfish? ◯ Yes ◯ No Reaction: _____

Do you want more children? ◯ Yes ◯ No Would you like to talk to the physician about permanent birth control? ◯ Yes ◯ No

GYNECOLOGIC HISTORY

Age at first period? _____ First day of your last period? _____ How many days does it last? _____

How many days from the start of one period to the start of another? _____ Describe your flow: ◯ Light ◯ Medium ◯ Heavy

Do you bleed between periods? ◯ Yes ◯ No Do you pass clots? ◯ Yes ◯ No Do you have pain with your period? ◯ Yes ◯ No

Do you miss school/work from pain? ◯ Yes ◯ No Are you sexually active? ◯ Yes ◯ No Do you have pain with sex? ◯ Yes ◯ No

Do you have any concerns with your sexual experience? ◯ Yes ◯ No Do you have any STDs? Herpes, Chlamydia, HPV or other? ◯ Yes ◯ No

Have you had an abnormal pap smear? ◯ Yes ◯ No Do you have pelvic pain? ◯ Yes ◯ No Do you have a problem with infertility? ◯ Yes ◯ No

Have you had any procedures on your cervix? If yes, what type? ◯ Colposcopy ◯ LEEP ◯ Cryo

Fax 731-422-2277

Woman's Clinic, P.A. –Intake Form, Page 2

TESTS / IMMUNIZATIONS

Test	Date of Last	Result	Test/Immunization	Date of Last	Result
Pap Smear			Colonoscopy		
Mammogram			Pneumonia / Flu Vaccine		
Bone Density			Other Vaccines such as Gardasil and Tetanus		

PREGNANCY HISTORY
(Please Include: Miscarriages, Ectopic Pregnancies and Abortions)

#	Date of Birth	Length of Pregnancy	Labor Hours	Birth Weight	Sex of Child	Delivered Vaginal-ly or C-Sec?	Epidural, Spinal, IV meds for pain?	Early Labor (Yes/No)	Complications

LIST SURGERIES

Procedure	Date	Procedure	Date	Procedure	Date

SOCIAL HISTORY

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Engaged ◯ Widowed

Have you ever used any nicotine products? ◯ Yes ◯ No ◯ Cigarettes ◯ Vape ◯ Cigars ◯ Oral tobacco

Alcohol Use: ◯ Yes ◯ No Number of drinks per week:

Recreational Drug Use: ◯ Yes ◯ No If yes, what type:

Have you ever been physically abused? ◯ Yes ◯ No Are you currently safe? ◯ Yes ◯ No

Do you exercise regularly? ◯ Yes ◯ No If yes, how often? Are you interested in Botox, Fillers or Laser? ◯ Yes ◯ No

REVIEW OF SYMPTOMS (Please mark all that apply)

Symptom	Yes	Symptom	Yes	Symptom	Yes	Symptom	Yes
Change in Height		Breast Tenderness		Blood in Urine		Muscle Weakness	
Fatigue		Nipple Discharge		Difficulty with Urinating		Hair Loss	
Loss of Appetite		Chest Pain		Frequency of Urination		Heat/Cold Intolerance	
Weight Gain		Fainting		Incomplete Emptying of Bladder		Hot Flashes	
Weight Loss		Irregular Heart Beat		Painful Urination		Night Sweats	
Headache		Lower Extremity Swelling		Urgency to Urinate		Anxiety / Depression	
Lightheadedness		Shortness of Breath		Urine Loss with Cough/Sneeze		Bleed Easily	
Vertigo		Blood in Stool		Memory Difficulties		Easy Bruising	
Breast Lumps		Constipation		Joint Pain		Enlarged Lymph Glands	
Breast Swelling		Heart Burn		Muscle Pain			