Provider: _____ Appt. Date _____ Time _____

Legal Name _____ Date of Birth _____

Prefered Name_____ Prefered Pronoun_____

(Please complete this form and bring at the time of your visit)

Welcome to Womens Group of North Florida! Please let the nurse know if you are unsure about how to answer any of the questions below. You will have the opportunity to ask questions and discuss in detail any part of this history and medical problems that you may have.

THIS IS PART OF YOUR MEDICAL RECORD AND IS KEPT ABSOLUTELY CONFIDENTIAL.

Reason for Your Visit today: _____

Who is your Primary Care Provider or other Doctors? _____ ☐ None

YOUR MEDICAL HISTORY

☐ Cancer (any type)	☐ Intestinal Problems	☐ Multiple Sclerosis	☐ Lung Disease
☐ Heart Problems	☐ Anemia / Low Iron	☐ Stroke or CVA or TIA	☐ Sleep Apnea
☐ High Blood Pressure	☐ Bleeding/Clotting Disorders	☐ Chronic Back Pain	☐ Rheumatoid Arthritis
☐ High Cholesterol	☐ History of Blood Transfusion	☐ Degenerative Joint Disease	☐ Autoimmune Disease
☐ Skin Problems	☐ Hx DVT/Pulmonary Embolism	☐ Bone Fractures	☐ Fibromyalgia
☐ Ears,Nose,Throat Problems	☐ Bleeding Disorders	☐ Other Bone Disease	☐ Frequent UTIs
☐ Seasonal Allergies	☐ Had Chicken Pox / Shingles	☐ Attention Deficit Disorder	☐ Blood in Urine
☐ Diabetes (or Gestational)	☐ HIV / AIDS	☐ Anxiety	☐ Kidney Problems
☐ Osteoporosis / Osteopenia	☐ MRSA	☐ Bipolar Disorder	☐ Kidney Stones
☐ Thyroid Problems	☐ Tuberculosis	☐ Depression	☐ Interstitial Cystitis
☐ Eye Disease or Problems	☐ Kidney Disease	☐ Eating Disorder	☐ Urinary Incontinence
☐ Bowel Problems or Polyps	☐ Headaches / Migraines	☐ PMS or PMDD	☐ Obesity
☐ Liver Disease or Hepatitis	☐ Memory Loss / Dementia	☐ Asthma	☐ Aneurysm
☐ Stomach Problems	☐ Seizure Disorder	☐ COPD/Emphysema	☐ Other Problems?

_____

_____

_____

_____

SURGERIES (please list any surgery you have ever had—*attach extra page if needed*)

Date _____procedure_____

Date _____procedure_____

Date _____procedure_____

MEDICATIONS

It is now possible to electronically access your active prescription medications list directly from the pharmacy, and the nurse will review this information with you. *May we access your medication list?* ☐ YES ☐ NO

_____ _____

_____ _____

_____ _____

MEDICATION ALLERGIES (please list reactions)_____

_____ *Latex Allergy? ☐ YES ☐ NO

FAMILY HISTORY (please check which family member had these problems) ☐ I was adopted ☐ Family History Unknown

	M	F	S	B	*Please specify mother or father's side of family for Aunts, Uncles and Grandparents
High Blood Pressure					
Stroke					
Heart Disease					
Osteoporosis					
Diabetes					
Psychiatric Disorders					

FAMILY CANCER HISTORY **The types of cancer listed below can be associated with an increased risk of breast cancer*

	M	F	S	B	*Please specify mother or father's side of family for Aunts, Uncles and Grandparents
Breast					
Ovarian					
Uterine					
Colon					
Pancreatic					
Prostate					
Other Cancers					

GYNECOLOGIC HISTORY (please list the approximate date that you have had the following)

Mammogram _____ ☐ N/A
Colonoscopy _____ ☐ N/A
Bone Density _____ ☐ N/A
Pap smear _____ ☐ N/A
FIRST DAY of your most recent menstrual period _____

Have you had the entire HPV vaccine series? Yes ☐ No ☐
Have you ever had an abnormal Pap smear? Yes ☐ No ☐
Are you currently sexually active? Yes ☐ No ☐
What is your gender identity? _____
What is your sexual orientation? _____
Have you ever had a sexually transmitted infection? No ☐
_____
What is your current form of birth control? ☐ None
_____
At what age did you first start having periods?_____

At what age did you stop having periods (menopause) _____
Do you use post-menopausal hormone medications? No ☐
_____
Do you a history of Endometriosis? Yes ☐ No ☐
Do you have uterine fibroids? Yes ☐ No ☐
Do you have a history of infertility? Yes ☐ No ☐
Do you have a history of recurrent ovarian cysts? Yes ☐ No ☐
Have you been diagnosed with polycystic ovarian syndrome? No ☐
_____

PREVIOUS BIRTHS / MISCARRIAGES / TERMINATIONS / TUBAL (ECTOPIC) PREGNANCIES / ADOPTIONS

Delivery Date	Type of Delivery	Sex	Baby Weight	Complications during Pregnancy or Delivery

SOCIAL HISTORY

Do you now, or have you ever smoked cigarettes? Yes ☐ No ☐ How Much?_____ For How Long?_____
Do you exercise regularly? Yes ☐ No ☐ ☐ Occasional ☐ Moderate ☐ Heavy
Do you drink beer, wine, or other alcohol? Yes ☐ No ☐ ☐ Occasional ☐ Moderate ☐ Heavy
Do you use street drugs or narcotics regularly? Yes ☐ No ☐ Describe: _____
Usual Caffeine Intake ☐ Occasional ☐ Moderate ☐ Heavy
Do you eat a special diet? Yes ☐ No ☐ Describe: _____
Your marital status? ☐ Engaged ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner
Have you ever felt threatened or been abused by anyone, and if so – when and by whom? No ☐
_____
Highest level of education completed _____
What is your current occupation? _____ Are you retired? No ☐
Do you have a religious preference? _____
Do you wear a seatbelt every time in the car? Yes ☐ No ☐ Is a blood transfusion acceptable in an emergency? Yes ☐ No ☐

Please let your nurse know if you were unsure how to answer any of the above questions