Complete WOMENS CARE CENTER

obstetrics gynecology menopause fertility wellness cosmetic gynecology

PEDIATRIC/TEEN NEW PATIENT HISTORY

DATE:

PERSONAL PROFILE

NAME:	NAME YOU WOULD LIKE US TO USE:
AGE:	GRADE IN SCHOOL (IF APPLICABLE):
BIRTH DATE:	

CONTACT INFORMATION

PARENT/LEGAL GUARDIAN NAME(S):	PARENT/LEGAL GUARDIAN PHONE NUMBER(S):
PARENT/LEGAL GUARDIAN ADDRESS:	NAME, PHONE NUMBER, EMAIL OF WHO TO CONTACT WITH RESULTS:
PATIENT'S PHONE NUMBER:	PATIENT'S EMAIL ADDRESS:

GYNECOLOGIC HISTORY

ARE YOU CURRENTLY PREGNANT?	CURRENT BIRTH CONTROL:
LAST MENSTRUAL PERIOD (FIRST DAY):	HISTORY OF VAGINAL INFECTION OR STD?
AGE PERIODS BEGAN:	HISTORY OF PREGNANCY? NO _____YES _____
NUMBER OF DAYS BLEEDING:	RECEIVED GARDASIL VACCINE?
NUMBER OF DAYS BETWEEN PERIODS:	_____NO _____YES (DATE) _____
ANY RECENT CHANGES IN PERIODS?	ARE YOU CURRENTLY SEXUALLY ACTIVE?
SEXUAL ORIENTATION:	

MEDICATIONS (INCLUDE OVER-COUNTER)

	DRUG NAME/DOSE		DRUG NAME/DOSE
1		3	
2		4	

MEDICATION ALLERGIES

1	
2	
3	

SOCIAL HISTORY

CIGARETTES _____NEVER _____CURRENT _____PAST _____PACKS PER DAY _____YEARS

ALCOHOL _____NONE _____#DRINKS PER DAY _____#DRINKS PER WEEK

RECREATIONAL DRUGS (DESCRIBE) _____CURRENT _____PAST

HAVE YOU BEEN SEXUALLY ABUSED, THREATENED OR HURT BY ANYONE?_____NO _____YES

PERSONAL PAST MEDICAL HISTORY			
HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS? (PAST OR CURRENT)			
	YES	**NO**	**DETAILS (DATE/DESCRIPTION)**
ABNORMAL HAIR GROWTH/HAIR LOSS			
ABNORMAL VAGINAL DISCHARGE			
ABNORMALLY PAINFUL/HEAVY PERIODS			
ARTHRITIS/JOINT PROBLEMS			
ASTHMA OR LUNG DISEASE			
BLOOD CLOTS IN LEGS OR LUNGS			
BLOOD TRANSFUSION			
BOWEL PROBLEMS			
CANCER			
DEPRESSION/ANXIETY			
DIABETES			
ENDOMETRIOSIS			
HEART ATTACK/ANGINA			
HERPES			
HIGH BLOOD PRESSURE			
INFERTILITY			
INVOLUNTARY LOSS OF STOOL			
INVOLUNTARY LOSS OF URINE			
IRREGULAR OR ABSENT PERIODS			
KIDNEY INFECTION/STONES			
LUMPS OR PAIN IN BREASTS			
LUPUS/ COLLAGEN VASCULAR DISEASE			
MENOPAUSE SYMPTOMS			
PREMATURITY? WHAT GESTATIONAL AGE?			
OTHER:			

CONDITIONS CONTINUED:	YES	NO	DETAILS (DATE/DESCRIPTION)
MIGRAINES/HEADACHES			
REFLUX/STOMACH ULCER			
SEIZURES			
SEXUALLY TRANSMITTED DISEASES			
STROKE			
SUBSTANCE ABUSE			
THYROID DISEASE			
UNEXPLAINED WEIGHT LOSS OR GAIN			
UTERINE FIBROIDS			

OPERATIONS/ HOSPITALIZATIONS

PROCEDURE/ REASON HOSPITALIZED	DATE	HOSPITAL	COMPLICATIONS
1			
2			
3			
4			
5			
6			

FAMILY HISTORY

MOTHER _____LIVING _____DECEASED- AGE/ CAUSE OF DEATH

FATHER _____LIVING _____DECEASED- AGE/ CAUSE OF DEATH

SIBLINGS #LIVING_____ #DECEASED_____ AGES/ CAUSES OF DEATH

CHILDREN #LIVING_____ #DECEASED_____ AGES/ CAUSES OF DEATH

ILLNESS	YES	WHICH RELATIVES/ AGE OF ONSET
BIRTH DEFECTS		
BLOOD CLOTS IN LEGS/LUNGS		
BREAST CANCER		
COLON CANCER		
CYSTIC FIBROSIS		
DOWNS SYNDROME		
HEART DISEASE		

HIGH BLOOD PRESSURE		
FAMILY HISTORY CONTINUED	**YES**	**WHICH RELATIVES/ AGE OF ONSET**
HIGH CHOLESTEROL		
OVARIAN CANCER		
SICKLE CELL DISEASE		
STROKE		
TAY SACHS DISEASE		
UTERINE CANCER		
OTHER FAMILY HISTORY		

REVIEW OF SYSTEMS

ARE YOU CURRENTLY EXPERIENCING ANY PROBLEMS WITH THE FOLLOWING BODY SYSTEMS? (CIRCLE THOSE THAT APPLY)

GENERAL ☐ fatigue ☐ fever ☐ weight gain ☐ weight loss

HEAD/EARS/NOSE/THROAT ☐ headaches ☐ sore throat ☐ decreased hearing

BREAST ☐ breat lumps ☐ breast tenderness ☐ nipple discharge

CARDIOVASCULAR ☐ chest pain ☐ irregular heartbeat

RESPIRATORY ☐ shortness of breath ☐ cough ☐ wheezing

GASTROINTESTINAL ☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation ☐ abdominal pain

SKIN ☐ rashes ☐ skin lesions

NEUROLOGIC ☐ seizures ☐ tingling ☐ numbness

MUSCULOSKELETAL ☐ joint pain ☐ joint swelling

ENDOCRINE ☐ hair loss ☐ temperature intolerance ☐ abnormal hair growth

PRIMARY CARE PHYSICIAN:

PRIMARY CARE PHYSICIAN PHONE NUMBER, ADDRESS, NAME OF PRACTICE:

DID YOUR PRIMARY CARE PHSYICIAN SEND YOU TO CWCC?

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE:

ARE YOU HERE TODAY FOR A _____ROUTINE ANNUAL EXAM OR A PROBLEM?_____

IF YOUR VISIT IS FOR A PROBLEM, PLEASE DESCRIBE:

THANK YOU!