

Whole Woman's Health of Austin

8401 North IH 35 * Austin, TX 78753

(512) 250 - 1005 * (800) 282 - 1005

PATIENT INFORMATION

Name:		Date:
Address:		City, State, Zip:
Home Phone:	Cell Phone:	Work Phone:
Social Security #:	Date of Birth:	Age:
Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	
Marital Status:	Race:	E-mail:
Federal privacy rules require that you tell us how to contact you with information, lab results, appointment changes, and other information that is crucial to your care with us. Please check all that apply:		
Call me at my home phone number and say:		Call me on my cell phone number and say:
<input type="checkbox"/> "Whole Woman's Health called"		<input type="checkbox"/> "Whole Woman's Health called"
<input type="checkbox"/> "Your doctor's office called"		<input type="checkbox"/> "Your doctor's office called"
The best way to mail information to me is: <input type="checkbox"/> Clinic Envelope <input type="checkbox"/> Plain Envelope		
There may be critical situations that arise which require Whole Woman's Health to make contact with you quickly. If unable to do so, Whole Woman's Health may send certified mail to your home address as a way to make direct contact.		

EMERGENCY CONTACT

Name:	Relationship:
Home Phone:	Work Phone:
Cell Phone:	
Is this person aware of the nature of your care with us? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, is it OK to discuss with them in case of emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No	

REVIEW OF SYSTEMS

Yes	No		Yes	No	
GENERAL			CARDIOVASCULAR		
		1. Generally good health			29. Mitral Valve Prolapse
		2. Recent physical exam. Date:			30. Heart murmur/heart attack
		3. Unexplained weight loss or gain (more than 10 lbs.)			31. Varicose veins
		4. Night sweats/hot flashes			32. Blood clots (head, leg, lungs)
		5. Frequent yeast infections			33. Stroke or stroke-like problems
		5. Cancer. If yes, where/when?			34. High blood pressure
		6. Smoke cigarettes. If yes, how many per day?			35. High Cholesterol
		7. Alcohol consumption. If yes, how many per week?	RESPIRATORY		
		8. Recreational drug use. If yes, what drugs and how often?			36. Asthma , Chronic cough, or other breathing problems
		9. Birth defects or genetic problems			37. Tuberculosis, or exposure to tuberculosis
		10. Are you being treated for any illness/condition now? If yes, what?	GASTROINTESTINAL		
		11. Do you currently take any medication (prescription, over the counter, herbal)? If yes, name:			38. Stomach or bowel problems, IBS
EYES					39. Liver problems (hepatitis, tumor, etc.)
		12. Eye problems (besides glasses or contacts)?			40. Gallbladder problems
EARS, NOSE, MOUTH, THROAT			SKIN		
		13. Hearing problems			41. Acne, rash, or other problems. If yes, what?
		14. Frequent nosebleeds	NEUROLOGICAL		
		15. Frequent sore throat or sinus problems			42. Migraine headaches. If yes, have they been diagnosed?
MUSCULOSKELETAL					43. Seizures/epilepsy
		16. Arthritis or osteoporosis			44. Recurring numbness in arms or legs
GENTOURINARY			ENDOCRINE		
		17. Bladder or kidney problems, frequent UTIs			45. Thyroid
		18. Uterine Fibroids			46. Diabetes
		19. Ovarian Cysts	HEMATOLOGICAL/LYMPHATIC		
		20. Breast Lump or Discharge			47. Anemia
		21. Have you had a mammogram? If yes, when?			48. Sickle cell disease/trait
		22. Vaginal discharge that burns or has odor			49. Blood clotting disorder
		23. Endometriosis	PSYCHOLOGICAL		
		24. Pain with sex			50. Depression requiring treatment. If yes, what treatment or medication?
		25. Have you ever had an abnormal pap? If yes, when? What were the results?			51. Other problems. If yes, what?
		26. Have you had a pap smear in the last year? If yes, when?			
		27. Did your mother take DES while pregnant with you?			
		28. Have you ever had a sexually transmitted infection? If yes, what type? When?			

REVIEW OF SYSTEMS (continued)					
IMMUNOLOGY			ALLERGY		
		52. Tetanus shot. When?			54. Are you allergic to any drug, food, or other substance? If yes, what?
		53. Have you ever had Rubella (German measles) or the immunization?			55. Do you suffer from seasonal or environmental allergies?
HOSPITALIZATION AND SURGERIES			FAMILY HISTORY		
Year	Reason		Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No		
			Have any of your immediate biological family had the following?		
			Yes	No	Diagnosis
					Osteoporosis
					Diabetes
					Heart attack/stroke before age 55
					High blood cholesterol or fats
					Genetic problems
					Cancer
					Other
MENSTRUAL HISTORY			PREGNANCY HISTORY		
At what age did periods begin?			Year		
Are your periods usually regular?				<input type="checkbox"/> Vaginal delivery <input type="checkbox"/> C-section <input type="checkbox"/> Abortion <input type="checkbox"/> Miscarriage	
Length of period (in days):				<input type="checkbox"/> Vaginal delivery <input type="checkbox"/> C-section <input type="checkbox"/> Abortion <input type="checkbox"/> Miscarriage	
Number of pads/tampons used on heaviest day:				<input type="checkbox"/> Vaginal delivery <input type="checkbox"/> C-section <input type="checkbox"/> Abortion <input type="checkbox"/> Miscarriage	
Last period on: <input type="checkbox"/> Normal <input type="checkbox"/> Not normal				<input type="checkbox"/> Vaginal delivery <input type="checkbox"/> C-section <input type="checkbox"/> Abortion <input type="checkbox"/> Miscarriage	
Do you experience (before or during): <input type="checkbox"/> cramps <input type="checkbox"/> bloating <input type="checkbox"/> bowel changes <input type="checkbox"/> emotional changes				<input type="checkbox"/> Vaginal delivery <input type="checkbox"/> C-section <input type="checkbox"/> Abortion <input type="checkbox"/> Miscarriage	
Do you ever have bleeding after sex? <input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Vaginal delivery <input type="checkbox"/> C-section <input type="checkbox"/> Abortion <input type="checkbox"/> Miscarriage	
Do you ever have bleeding between periods? <input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Vaginal delivery <input type="checkbox"/> C-section <input type="checkbox"/> Abortion <input type="checkbox"/> Miscarriage	
SOCIAL HISTORY			STI RISKS		
Have you experienced:		Comments:	Yes	No	
<input type="checkbox"/> Emotional problems					Have you had more than one sexual partner in the last year?
<input type="checkbox"/> Relationship problems					Have you engaged in <input type="checkbox"/> oral <input type="checkbox"/> vaginal <input type="checkbox"/> anal sex?
<input type="checkbox"/> Death of someone close to you					Was any partner <input type="checkbox"/> a street drug user <input type="checkbox"/> a Hemophiliac <input type="checkbox"/> infected with HIV/AIDS?
<input type="checkbox"/> Job loss <input type="checkbox"/> Financial problems					Have you shared needles? <input type="checkbox"/> IV drug use <input type="checkbox"/> tattoos <input type="checkbox"/> piercing <input type="checkbox"/> other
<input type="checkbox"/> Legal problems <input type="checkbox"/> Divorce					Have you received blood or blood products?
<input type="checkbox"/> School problems			Comments or other information:		
<input type="checkbox"/> Housing problems					
<input type="checkbox"/> Abuse (verbal, sexual, physical)					
<input type="checkbox"/> Nonconsensual sex					
<input type="checkbox"/> Fear of partner or family member					
Who supports you when you have problems?					

To the best of my knowledge, the information I have provided is correct. I have received and understand the Patient Privacy Notice.

Patient's Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Staff notes (by number):