THE WOMEN'S HEALTH GROUP, PC

SYMPTOM REVIEW

NAME_____ **DATE**_____

PLEASE NOTE ANY SYMPTOMS YOU HAVE RECENTLY HAD THAT YOU FEEL ARE ASSOCIATED WITH YOUR VISIT TODAY. IT IS NORMAL NOT TO HAVE MOST OF THESE SYMPTOMS.

CONSTITUTIONAL	[ ] Fatigue	[ ]Weight Loss	[ ]Weight Gain
	[ ]Other_____		
EYES	[ ]Glasses/Contacts	[ ]Other_____	
HEAD/NECK	[ ]Sinus Congestion	[ ]Dentures	[ ]Decreased Hearing
	[ ]Other_____		
BREAST	[ ]Lumps	[ ]Tenderness	[ ]Nipple Discharge
	[ ]Other_____		
CARDIOVASCULAR	[ ]Chest Pain	[ ]Irregular Heart Beat	[ ]Fainting
	[ ]Other_____		
RESPIRATORY	[ ]Shortness of Breath	[ ]Wheezing	[ ]Cough
	[ ]Other_____		
GASTROINTESTINAL	[ ]Nausea	[ ]Vomiting	[ ]Diarrhea
	[ ]Constipation	[ ]Blood in Stools	[ ]Other_____
GENITOURINARY	[ ]Urgency	[ ]Frequency	[ ] Dysuria
	[ ]Incontinence	[ ]Decreased Libido	[ ]Other_____
SKIN	[ ]Rash	[ ]Changes in Moles	[ ]Changes in Lesions
	[ ]Other_____		
NEUROLOGICAL	[ ]Muscular Weakness	[ ]Incoordination	[ ]Tingling/Numbness
	[ ]Other_____		
MUSCULOSKELETAL	[ ]Joint Pain	[ ]Muscle Pain	Other_____
ENDOCRINE	[ ]Frequent Urination	[ ]Constant Drinking	[ ]Cold Intolerance
	[ ]Heat Intolerance	[ ]Other_____	
PSYCHIATRIC	[ ]Anxiety	[ ]Depression	[ ]Difficult Sleeping
	[ ]Other_____		
HEME-LYMPH	[ ]Easy Bleeding	[ ]Easy Bruising	[ ]Lymph Node Pain
ALLERGIC-IMMUNE	[ ]Sinus Symptoms	[ ]Frequent Illness	[ ]Other_____

MENSTRUAL HISTORY

Menses began _____y/o Cycle Interval _____days Duration _____ days

[ ] light [ ] medium [ ] heavy Last period _____

Birth Control Method_____ [ ] Home Pregnancy Test [ ] Positive [ ] Negative

[ ] Peri-menopause [ ] Menopause Age began_____

THE WOMENS HEALTH GROUP, PC

Patient Questionnaire

Patient Name_____ **DOB**_____
Reason for visit _____**DATE**_____
Last Annual exam: Date_____
Last Colonoscopy: Date_____ Result_____
Last Diabetes Screen: Date_____ Result_____
Last Cholesterol Screen: Date_____ Result_____
Last Mammogram: Date_____ Result_____
Last Osteoporosis Screen: Date_____ Result_____
Last Pap Screen: Date_____ Result_____
Last Thyroid Screen: Date_____ Result_____

PAST GYNECOLOGICAL HISTORY

[ ]Birth control
Type_____
[ ]Cervical Dysplasia
[ ]Fluid in fallopian tubes
[ ]Vaginal Dysplasia
[ ]Vulvar Dysplasia
Other_____

[ ]Ectopic Pregnancy
[ ]Endometriosis
[ ]Fibroids
[ ]Herpes
[ ]Infertility
[ ]Menopause

[ ]No Periods
[ ]Abnormal Bleeding
[ ]Painful Periods
[ ]Pelvic Pain
[ ]Pelvic Infection
[ ]Pelvic Mass
[ ]Pelvic Prolapse

PAST MEDICAL HISTORY

[ ]Abnormal Mammogram
[ ]Breast Cyst
[ ]Fibrocystic Breast Disease
[ ]Breast Discharge
[ ]Breast Mass
[ ]Breast Pain

[ ]Cancer
Type_____
[ ]High Blood Pressure
[ ]High Cholesterol
[ ]Heart Palpitations
[ ]Mitral Valve Prolapse
[ ]Diabetes Type_____

[ ]Seizure Disorder
[ ]Alcohol/Drug Abuse
[ ]Anxiety Disorder

[ ]Bipolar Disorder
[ ]Depression
[ ]Other_____

[ ]Elevated Prolactin
[ ]Hyperthyroid
[ ]Hypothyroid
[ ]Metabolic Syndrome
[ ]Obesity
[ ]Polycystic Ovarian Syndrome
[ ]Lupus

[ ]Anal Fissures
[ ]Constipation
[ ]Reflux Disease/Heartburn
[ ]Hemorrhoids
[ ]Irritable Bowel Syndrome

[ ]Seasonal Allergies
[ ]Asthma
[ ]COPD/Obstructive Bronchitis
[ ]Chronic Sinusitis

_____

[ ]Anemia
[ ]Blood Transfusion in past
[ ]Coagulation Disorder
[ ]Varicose Veins
[ ]Blood clot in leg/lung
[ ]Von Willebrand's Disease

[ ]Chronic Back Pain

[ ]Fibromyalgia
[ ]Osteopenia
[ ]Osteoporosis
[ ]Headaches/Migraines

[ ]Interstitial Cystitis
[ ]Bladder urgency
[ ]Protein/Blood in Urine

[ ]Kidney/Bladder Infections
[ ]Incontinence/Loss of urine
[ ]Kidney Stones

PAST GYNECOLOGICAL SURGERY

[ ]Cesarean Section
[ ]Ectopic Pregnancy
[ ]Hysteroscopy
[ ]Hysterectomy

[ ]Laparoscopy
[ ]Prolapse/Incontinence
[ ]Sterilization

Number_____
Side_____
Date_____
Date_____
[ ]Ovaries Removed
Date_____
Date_____
Date_____

Reason_____
Treatment_____
Diagnosis_____
Diagnosis/Type_____
Reason_____
Diagnosis_____
Type_____
Type_____

PAST SURGERIES

[ ]Abdominal Surgery
[ ]Ankle Surgery
[ ]Appendix
[ ]Bariatric - LapBand
[ ]Bariatric – Roux-en-Y
[ ]Bronchoscopy
[ ]Cataract Surgery

[ ]Gall Bladder Removed
[ ]Colonoscopy
[ ]Brain Surgery
[ ]Bladder Scope
[ ]Foot Surgery

[ ]Hand Surgery
[ ]Hemorrhoid Surgery
[ ]Hernia Repair
[ ]Knee Surgery
[ ]Lasik
[ ]Spine Surgery
[ ]Neck Surgery
[ ]Plastic Surgery

[ ]Shoulder Surgery
[ ]Sinus Surgery
[ ]Skin Biopsy
[ ]Skin Tag Removal
[ ]Spleen Removed

[ ]Chest Surgery
[ ]Thyroid Removed
[ ]TMJ Surgery
[ ]Tonsils/Adenoids
[ ]Hip Replacement
[ ]Knee Replacement
[ ]Other_____

_____

MEDICATIONS

TYPE_____DOSE_____DATE STARTED_____

_____

_____

_____

ALLERGIES _____

FAMILY HISTORY

[ ]Breast Cancer_____
[ ]Colon Cancer_____
[ ]Kidney Cancer_____

[ ]Ovarian Cancer_____
[ ]Prostate Cancer_____

[ ]Uterine Cancer_____

[ ]Heart Disease_____
[ ]Thyroid Disease_____
[ ]Hypo [ ]Hyper

[ ]Osteoporosis
[ ]Problems w. Anesthesia

[ ]Sickle Cell Disease/Trait
[ ]Lupus
[ ]Blood Clots/Coagulation D/O

[ ]Von Willebrand's Disease
[ ]Other_____

_____