



North Scottsdale
 Women's Care, P.C.
 Obstetrics & Gynecology

Established Patient History Form

Pt's Name _____ Date of Birth _____ Age _____ Today's Date _____

Would you like results sent to your primary care physician? Yes / No (If yes, please provide name and fax number)

1. GYNECOLOGICAL HISTORY: Any gynecological problems since your last examination? Yes; No (If yes, please explain)

- First day of last period _____ - Date of last Mammogram _____
- Duration of flow _____ - Date of last Pap Smear _____
- Time between periods _____ - Are you sexually active? _____
- Date of last Bone Density Scan _____ - Do you use contraception? Yes; No (If yes, type?) _____

2. MEDICAL HISTORY: Any medical problems since your last examination? Yes; No (If yes, please explain)

- Do you take calcium? Yes; No
- List current Medications
 (include vitamin and herbal supplements) _____
- List any Allergies to Medication _____
- Any Surgeries/Hospitalizations since your last examination? (If yes, please explain):

3. FAMILY HISTORY: Any changes to your family history since your last examination? Yes; No (If yes, please explain)
 (For example, breast cancer, ovarian cancer, uterine cancer and/or colon cancer?)

4. SOCIAL HISTORY: Any changes to your social history since your last examination? Yes; No

- Do you exercise regularly? Yes; No Current Occupation: _____
- Marital status? Single Married Separated Divorced Widow Other
- Do you smoke cigarettes? Yes; No If yes, at what age did you start? _____ Packs per day? _____
- Do you drink alcohol? Yes; No If yes, amount? _____ If yes, how often? _____
- Do you use drugs socially? Yes; No If yes, amount? _____ If yes, how often? _____
- Are you a victim of domestic violence or abuse in your present relationship? Yes; No Past Relationship? Yes; No
- Do you have a living will? Yes; No

5. REVIEW OF SYSTEMS

Abdomen:

Diarrhea? Yes No Constipation? Yes No Other: _____

Genitourinary:

Frequent urination? Yes No Urinary Incontinence? Yes No Other: _____

Skin/breast:

Lumps in breast? Yes No Nipple discharge? Yes No Other: _____

Any other problems?

Completed by: _____ Date: _____

Reviewed by: _____ Date: _____

(Signature of Provider)