University Women's Wellness
1801 N University Dr., Suite 201, Coral Springs, FL 33071
Office: 954-644-0149 Fax: 855-592-1225

Full name: ______________________ Date of birth (MM/DD/YYYY): ______________________

Reason for visit: ______________________

Please list any other questions or concerns about your health that you would like to discuss today:

MEDICATIONS: Please list all medications currently taking including birth control, vitamins and supplements.

ALLERGIES: Please list any allergies to medications including food, environmental exposures, latex, etc. or write NONE.

PAST MEDICAL HISTORY: Please list all previous medical conditions including diseases, and related hospitalizations.

PAST SURGICAL HISTORY: Please list all previous surgeries including cesarean sections, abortions, and related hospitalizations, as well as complications (bleeding, infections, re-operations) and problems related to anesthesia.

OBSTETRIC HISTORY: Please list all pregnancies, including dates of deliveries, delivery types and any complications. Please also include miscarriages, terminations, pre-term deliveries and any ectopic pregnancies.

SOCIAL HISTORY:

Marital status:	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Use of alcohol:	☐ Never	Number of drinks per week:			
Use of tobacco:	☐ Never	Previously quit date:			Packs per day:
Use of drugs:	☐ Never	Type/frequency:			
History of sexual assault or domestic violence:					

FAMILY MEDICAL HISTORY: Please list any hereditary medical conditions, including cancer and heart disease.

Mother:

Father:

Siblings:

Children:

Other blood relatives:

GYNECOLOGIC HISTORY:

DATE of last pap smear:

DATE of last menstrual period:

History of abnormal pap smears	☐
Family history of breast or ovarian cancer	☐
Osteoporosis/osteopenia/low bone mass	☐
Endometriosis	☐
Infertility	☐
Sexually transmitted infections	☐
Pelvic inflammatory disease/PID	☐
Human papilloma virus (HPV infection)	☐

Have you completed the Gardasil/HPV vaccine?

If so, date of last dose:

Duration of menses (days):

Interval between periods (days):

Number of pads/tampons on heavy day:

Age at menarche (first period):

Uterine fibroids	☐
Polycystic ovary syndrome	☐
Endometriosis	☐
Menopause/perimenopause	☐

Do you currently use contraception?

If so, please explain:

DATE of last mammogram:

Date of last colonoscopy/Cologuard:

REVIEW OF SYSTEMS:

CONSTITUTIONAL SYMPTOMS

Fever or chills	☐
Fatigue	☐
Malaise	☐
Weight loss/gain	☐

EYES/EARS/NOSE/THROAT

Blurred or double vision	☐

ENDOCRINE

Hot flashes/night sweats	☐
Thyroid disease	☐
Diabetes/insulin use	☐
Osteoporosis/Osteopenia	☐
Excessive thirst or urination	☐
Heat or cold intolerance	☐

Chronic sinus problems/allergies ☐
Mouth sores ☐
Wear glasses/contact lenses ☐

CARDIOVASCULAR
Arrhythmia/Irregular heartbeat ☐
Chest pain or angina pectoris ☐
Lightheaded or dizzy ☐
Swelling of feet, ankles or hands ☐

RESPIRATORY
Asthma or wheezing ☐
Chronic or frequent cough ☐
Shortness of breath ☐
Spitting up blood ☐

GASTROINTESTINAL
Abdominal pain ☐
Constipation or diarrhea ☐
Nausea or vomiting ☐
Rectal bleeding or blood in stool ☐
Reflux disease/Heartburn ☐

GENITOURINARY
Abnormal menses/irregular periods ☐
Dysmenorrhea/painful periods ☐
Frequent or painful urination ☐
Heavy periods/clots ☐
Incontinence or loss of urine ☐
Kidney stones ☐
Nocturia/getting up at night to urinate ☐
Pelvic pain/pain with sex ☐
Vaginal discharge or odor ☐
Vaginal dryness/burning ☐

INTEGUMENTARY (SKIN/BREAST)
Breast pain/dense breasts ☐
Breast lump/mass ☐
Breast discharge ☐
Changing mole ☐
Change in hair or nails ☐
Rash or itching ☐

HEMATOLOGIC / LYMPHATIC
Anemia/past transfusion ☐
Bleeding or bruising tendency ☐
Enlarged/swollen glands ☐
Poor healing ☐

MUSCULOSKELETAL
Back pain ☐
Joint stiffness or swelling ☐
Motor vehicle accident or Sports injury ☐
Muscle pain or cramps ☐
Weakness of muscles or joints ☐

PSYCHIATRIC
Anxiety/nervousness ☐
Depressed mood or irritability ☐
Insomnia ☐
Memory loss or confusion ☐
Loss of appetite ☐

NEUROLOGICAL
Convulsions or seizures ☐
Headaches ☐
Numbness or tingling ☐
Recent Fall ☐
Stroke ☐

Additional notes: ____

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Patient signature: ______________________ Date: ____________