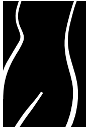

WOMEN'S SPECIALISTS OF NEW MEXICO, Ltd.

PATIENT HISTORY

Welcome to Women's Specialists of New Mexico. Please complete the following questions to allow us to provide you with the best health care. If you do not understand any question or do not want to answer any question, leave it blank. All answers will be confidential and will be reviewed with your provider.

PART ONE

Name ______________________________ Date of Birth ______________

What would you like to be called, if different from above? ______________________________

Occupation ______________ Marital Status ______________ Race __________ Age __________

How were you referred to our office (yellow pages, insurance, family/friend, physician) Other: ______________

Why are you here today? Routine Exam / Other ______________________________

Name of family physician ______________________________ Date last seen ______________

Have you had any of these tests within the last five years?

- ☐ Mammogram
- ☐ Pap Smear
- ☐ Blood Count
- ☐ Chemistry Profile
- ☐ Cholesterol Screen
- ☐ Lipid Profile
- ☐ Thyroid testing
- ☐ HIV (AIDS)
- ☐ Stool blood test
- ☐ Barium enema
- ☐ Sigmoidoscopy/colonoscopy
- ☐ EKG

Other test performed ______________________________

Abnormal test results ______________________________

First day of last menstrual period ______________

Date of last mammogram ______________

Date of last Pap Smear ______________

PART TWO: MEDICAL HISTORY & SYSTEMS REVIEW

Please check any past or current medical problems for yourself or immediate, blood relative.

X=Yourself
M=Mother
F=Father
B=Brother
S=Sister
Grandparents:
Maternal=MGM or MGF
Paternal=PGM or PGF

	You	Family
1. High blood pressure		
2. Diabetes		
3. Heart disease		
4. Lung disease, asthma		
5. Kidney disease		
6. Breast cancer		
7. Ovarian cancer		
8. Colon cancer		
9. Other cancers		
10. Migraine headache		
11. Hearing problems		
12. Thyroid disorder		
13. Tuberculosis		
14. Stroke		
15. Blood clots in legs or lungs		
16. Ulcers		

	You	Family
17. Gallbladder disease or gallstones		
18. Hepatitis		
19. Irritable bowel syndrome		
20. Hemorrhoids		
21. Frequent bladder infections		
22. Osteoporosis		
23. Anemia		
24. Arthritis		
25. Blood disorders		
26. Autoimmune disease (lupus, MS, etc.)		
27. Skin disorders		
28. Seizure disorder		
29. Alzheimer's		
30. Mental illness, depression		
31. Drug/alcohol abuse		
32. Other		

List any known **ALLERGIES** (drugs, food, hay fever, etc.) ______________________________

☐ No known allergies ______________________________

Name DOB Date

Provider's initials
(reviewed all three pages)

List any **MEDICATIONS** you are taking, to include birth control pills, Tylenol, Advil, aspirin, other non-prescription medicine, vitamins, herbs.

Do you exercise on a regular basis?	Yes	No		
Is your diet nutritionally balanced?	Yes	No		
Do you currently smoke?	Yes	No	How many per day:	How long? Years
Have you ever smoked?	Yes	No	When did you quit?	
Do you use recreational drugs?	Yes	No	Do you drink alcohol? Yes No Amount per week:	
Is alcohol or drug use a problem for you?	Yes	No		

List hospitalizations, surgeries, broken bones or serious injuries.			
Year	Problem/Diagnosis	Surgery/Operation	Comments

PART THREE: GYNECOLOGICAL HISTORY		
I. Have you ever had an abnormal Pap Smear?	Yes	No
How was it treated?		
Have you ever had an abnormal Mammogram?	Yes	No
How was it treated?		

II. Age when your periods started:		
Do you have a menstrual period?	Yes	No
If not, when did they stop?		
How often do you have a period? Every _____ to _____ days How many days do they last?		
Is your flow heavy?	Yes	No
Do you have spotting or bleeding between periods?	Yes	No
Is menstrual pain/cramping a problem for you?	Yes	No
Is PMS a problem for you?	Yes	No
Are you presently using birth control/contraception? (Pills, IUD, Tubal, Condoms, Vasectomy)	Yes	No
If yes, what type and brand:		
Are you interested in a different birth control method?	Yes	No

III Have you been sexually active within the last year?	Yes	No
Are you sexually active with ☐ male(s) ☐ female(s) ☐ both?		
Have you had a new sexual partner within the last year?	Yes	No

Name DOB Date

III. Do you have pain with intercourse?	Yes	No
Do you have bleeding with or after intercourse?	Yes	No
Do you have any concerns about sexual relations?	Yes	No
Do you have problems with bladder or bowel control?	Yes	No
Have you ever been diagnosed with a female infection?	Yes	No
If yes, please indicate: ☐ trichomonas ☐ gonorrhea ☐ chlamydia ☐ syphilis ☐ chronic yeast infection ☐ bacterial vaginosis ☐ vaginal herpes ☐ vaginal warts/HPV		
Have you ever been sexually abused?	Yes	No
Have you ever been physically or emotionally abused by anyone important to you?	Yes	No
Have you received counseling for these abuse issues?	Yes	No
Have you had a recent major stress (e.g., loss of job, loss of loved one, change in marital status)?	Yes	No
Would you like to be tested for HIV/AIDS?	Yes	No
Would you like to be tested for sexually transmitted infections?	Yes	No
Have you ever had an infertility problem or difficulty getting pregnant?	Yes	No

IV. Menopause/Perimenopause Do you have any of the following **menopause** or **perimenopause** symptoms? ☐ hot flushes ☐ vaginal dryness ☐ night sweats ☐ difficulty sleeping		
Are you using any non-medical treatments for the above symptoms?	Yes	No
If you are using hormone replacement therapy, are you satisfied with that method?	Yes	No
Are you interested in alternative therapies?	Yes	No

PART FOUR: OBSTETRICAL HISTORY (Please include any miscarriages.)

	Month/ Year	Number of weeks at delivery	Baby's sex	Baby's weight	Describe any problems during pregnancy, labor or delivery.	Vaginal/ Cesarean birth?
1.						
2.						
3.						
4.						
5.						
6.						

Please list any elective/voluntary pregnancy terminations (abortions).

Month/Year	Number of weeks

Name DOB Date