USF WOMEN'S HEALTH
UNIVERSITY OF SOUTH FLORIDA

Patient Name: _____ Date of Birth: _____
Occupation: _____ Gender: _____
Marital Status: _____ Name of Spouse/Partner: _____
Primary Physician: _____
Referring Physician: _____

Are you here for an: _____ Annual _____ Problem visit ____ Pregnancy
If you are scheduled for an annual but have a problem, please check with the front desk to find out about your copay/if you have coverage. Due to time constraints, we may be able to only see you for a problem OR an annual exam during your scheduled appointment.

If you are here for a problem, please explain:
_____
_____
_____
_____

Medical problems

- Anemia
- Anesthesia complications
- Asthma
- Blood transfusion
- Breast problems
- Congenital heart disease
- Diabetes
- DVT or Blood clot
- Hepatitis
- Herpes
- HIV/AIDS
- Hypertension
- Infertility
- Kidney Disease
- Lupus
- Mental Disorder
- Positive PPD
- Seizures
- Sickle cell anemia
- Spina bifida
- STD
- Thyroid disease
- Migraines
- Heart disease

Other: _____

Surgery

Please list year of surgery

- Appendix (Appendectomy)
- Breast surgery
- Gall bladder (Cholecystectomy)
- Conization of cervix
- C- section
- D&C (Dilation and curettage)
- LEEP
- Removal of ovary (Oophorectomy)
- Ovarian cyst removal
- Pelvic laparoscopy
- Removal of tube and ovary (Salpingoophorectomy)
- Removal of Tubes (Salpingectomy)
- Tubal ligation
- Hysterectomy

Other: _____

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Medications

Please include over the counter medications as well. Attach additional sheet as needed.

Name	Dose	Frequency	Prescribing Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

Medication	Reaction
_____	_____
_____	_____
_____	_____

Latex: Yes No

Family History

Parents deceased? Mother: _____ Father:_____ Adopted? _____

Problem	Relative and age of Diagnosis
Diabetes	_____
Deep Vein thrombosis	_____
Hypertension	_____
Stroke	_____
Ovarian Cancer	_____
Breast Cancer	_____
Uterine cancer	_____
Colon Cancer	_____
Bleeding disorders	_____

Obstetrical History

Pregnancies: _____ Abortions: _____ Miscarriages: _____

Ectopic pregnancies: _____ Living Children: _____

Year	Term/Preterm	Delivery Type	Weight	Complications
_____	_____	CS/ Vaginal	_____	_____
_____	_____	CS/ Vaginal	_____	_____
_____	_____	CS/ Vaginal	_____	_____
_____	_____	CS/ Vaginal	_____	_____
_____	_____	CS/ Vaginal	_____	_____

Complications:

- Negative blood type
- Not immune to chicken pox
- Gestational diabetes
- Postpartum hemorrhage (excessive bleeding after delivery)
- Baby over 10 lb
- Blood transfusion

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Social

How much/How often/How long?

Smoke Cigarettes? _____
Smokeless tobacco/nicotine? _____
Use Alcohol? What type? _____
Other Drugs? _____
Do you accept Blood transfusions? _____
Are you breast feeding? _____
Do you desire pregnancy now? _____
History of domestic violence or abuse? _____

Gynecologic History

Last menstrual period? _____
Periods occur every _____ days and last _____ days
Painful? _____ Heavy?_____

Are you sexually active? _____
Partner(s)? _____ Male _____Female
Any difficulties with your sex life? _____

Date and result of last pap smear? _____
Any abnormal paps? _____
If so, what treatment? _____

Any STDs:

- Gonorrhea
- Chlamydia
- Syphilis
- Trichomonas
- HIV
- Hepatitis B
- Hepatitis C
- HPV/Warts
- PID

Birth control used in the past:

- Condoms
- The Pill
- The Ring (Nuvaring)
- The patch (Orthoevra)
- Depo-Provera (Depo)
- Implant (Nexplanon/Implanon)
- Progesterone IUD (Mirena, Skyla, etc)
- Copper IUD (Paraguard)
- Tubal ligation
- Vasectomy
- Natural family planning/Rhythm

Menopause Symptoms:

- Hot flashes
- Vaginal Dryness
- Prolapse
- Incontinence
- Mood swings

Past treatments: _____

Health Screening

Last Mammogram? _____
Last colonoscopy? _____

Last Bone Density (DEXA) scan? _____
Did you have HPV vaccine (Gardasil)? _____
How often do you Exercise? _____
How much Calcium do you get (diet or supplements)?
_____
Do you wear your seatbelt? _____

Review of Symptoms- Please circle all that apply:

General
Weight loss /gain
Fever/ chills
Fatigue
Heat intolerance
Excessive thirst

ENT
Change in vision
Change in hearing
Sore throat
Nose bleeds

Cardiovascular
Chest pain
Loss of consciousness
Palpitations
Heart murmur

Respiratory
Painful breathing
Wheezing
Chronic cough
Shortness of breath

Gastrointestinal
Abdominal pain
Nausea/vomiting
Change in appetite
Frequent diarrhea
Constipation
Dark or blood stools
Indigestion
Involuntary loss of stool or gas

Hematologic
Easy bruising
Swollen lymph glands

Gynecologic
Pain or bleeding with intercourse
Irregular periods
Pelvic pain
Vulvar itching
Abnormal smell or odor
Sexual difficulty

Urinary
Painful urination
Frequent urination
Urinary urgency
Blood in urine
Urinary incontinence

Musculoskeletal
Back pain
Weakness
Joint pain or swelling

Breasts/skin
Breast lump
Nipple discharge
Breast pain
Change in hair
Change in moles/freckles
Rash

Neurologic
Memory changes
Numbness or tingling
Headaches
Seizures
Tremors

Psychiatric
Depression
Anxiety
Mood swing