Concorde Medical Group PLLC

Concorde Women's Health

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Name:_____ Date:_____
Age: _____ Date of Birth:_____
In your own words, what brings you into the office today?
_____
_____
_____
When was the first day of your last menstrual period? _____

Obstetrical History:
Number of Vaginal deliveries:_____ Number of Cesarean sections: _____

- Any of these deliveries preterm (before 37 weeks)? No □ Yes □ Which?_____
- Any complications with these deliveries? _____

Number of Miscarriages: _____ What year(s)? _____
Number of Abortions: _____ What year(s)? _____

- Any ectopic pregnancies? No □ Yes □ When? _____

Gynecologic History:
Age at first period: _____ Days between period: _____ Length of usual period: _____
If in menopause, how old were you at the time of last period: _____
Do you have any of the following? Please place a √ if you do.
Bleeding between periods? Yes □ Duration: _____days
Heavy menstrual periods? Yes □ Duration: _____days
Bleeding after intercourse? Yes □
Pain with periods? Yes □ Duration: _____days

Date of last Pap smear: _____ Date of last Mammogram: _____
Normal results? Yes □ No □ Normal results? Yes □ No □
Have you had any treatments to your cervix? If so, please indicate what year(s).
Cautery_____ Cryosurgery_____ LEEP_____ Conization_____
Date of last Bone Density: _____ Date of last Colonoscopy: _____
Normal results? Yes □ No □ Normal results? Yes □ No □

Have you ever had any sexually transmitted diseases? If yes, what year(s)?
Gonorrhea □_____ Chlamydia □_____ Herpes □_____ Genital warts _____
Are you sexually active at this time? Yes □ No □
With whom have you been sexually active? Men □ Women □ Both□
How many lifetime sexual partners have you had? _____
Do you have pain during intercourse? Yes □ No □
What forms of birth control have you used? _____
Do you have any questions about sex you would like to ask? Yes □ No □

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Name: _____ Date: _____

Do you ever lose urine with coughing or at other times? No □ Yes □
How long ago did this start? _____
Do you ever lose stool before reaching the toilet? No □ Yes □
How long ago did this start? _____

Please list all MEDICATIONS (include contraceptives and vitamins) you are taking and the dosage of each: _____
_____
_____
Please list all DRUG ALLERGIES you have and the reaction:
_____

Past Medical History:

□ Hypertension
□ Thyroid Disease
□ Heart Disease
□ Asthma
□ Cancer: _____
□ Diabetes
□ Stroke
□ Glaucoma
□ Liver Disease
□ Serious injury or accident:_____
□ Other: _____
_____

Past Surgical History:
Please list any SURGERIES and the year or your age at the time:
_____
_____
_____

Family History:
Who in your family has any of these diseases? If deceased, please indicate age at death.
High Blood Pressure _____ Kidney Disease _____
Diabetes _____ Urinary Incontinence _____
Stroke _____ Uterovaginal Prolapse _____
Breast Cancer _____ Heart Disease _____
Other Cancers _____ Other Diseases _____

Social History:
Are you currently in a relationship(s)? No□ Male□ Female□ For How Long?_____
Marital status: Single□ Married□ Domestic Partner □ Divorced□ Widowed□
Your occupation _____ Partner's occupation _____
Do you smoke? No□ Yes□ # packs per day_____ Quit□ What year? _____
Do you currently use: Alcohol □ Marijuana □ Cocaine □ Other□_____

- If so, how much? _____
- Have you used any of these regularly in the past? _____