Women's Health Care – Preventive Visit Update

Thank you for making an appointment with the Women's Health Care Center. Please take a moment to fill out this form and bring it with you to your appointment. All of your answers will be kept private.

Your name: ______________________ **Your age:** ________ **Today's date:** ____________

Which type of visit are you here for today? (Check *one*):

☐ Full preventive health review and physical exam
☐ Breast and pelvic exam (with Pap smear) only

Please check any of the items below that you hope to arrange or talk about at this visit:

☐ Arrange
  ☐ Blood work ☐ Mammogram ☐ Colon cancer screening ☐ Vaccination(s)
☐ Prescription refills (including birth control)
  How many days supply of one medicine does your insurance cover? (Please check one):
  ☐ 30 days ☐ 90 days ☐ Other: ____________
☐ Talk about recent labs or other recent tests (Specify): ______________________
☐ Obtain referral(s) (Please specify): ______________________
☐ Other concerns or questions: ______________________

____

Please list all medicines, vitamins, herbs, and supplements you take or sometimes take:

____
____
____
____

Please list all medication allergies you have now or have had in the past:

____
____

Since your last general physical exam, have you had any:

Yes	No	If "Yes," please give details.
☐	☐	Hospital stays, surgeries, or deliveries? ____________
☐	☐	Medical care from doctors outside UWMC? ____________
☐	☐	New medical conditions? ____________
☐	☐	Changes in job or living situation? ____________
☐	☐	Changes in family's medical history? ____________

Health Habits and Safety Concerns: (*Please check appropriate box for each item below*)

Yes	No	
☐	☐	Do you smoke? If yes, indicate amount ____________
☐	☐	Do you consider your diet to be healthy?
☐	☐	Have you had a new sexual partner in the past year?

How often, in the last year, have you had four or more alcoholic drinks on one occasion?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

(Continued on Reverse)

PT.NO

NAME

DOB

UW Medicine
Harborview Medical Center – UW Medical Center
University of Washington Physicians
Seattle, Washington

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Yes	No	
☐	☐	Do you feel safe in your home and your relationship(s)?
☐	☐	Have you been verbally or physically threatened or abused by anyone in the past year?
☐	☐	Do you always wear your car seatbelt and a bike helmet when you ride?
☐	☐	Is there a gun in your home?
☐	☐	Do you exercise for more than 30 minutes four or more days a week?

Recent Problems

For each item below, please show whether you have had any recent problems by checking yes or no:

	Yes	No
General:		
Weight change without trying	☐	☐
Unusual fatigue	☐	☐
Fevers	☐	☐
Loss of appetite	☐	☐
Awakening due to pain	☐	☐
Head/eyes/ears/throat:		
Changes in your eyesight	☐	☐
Hoarse voice	☐	☐
Difficulty swallowing	☐	☐
Difficulty hearing	☐	☐
Heart:		
Palpitation	☐	☐
Chest pain	☐	☐
High blood pressure	☐	☐
Lungs:		
Shortness of breath	☐	☐
Cough	☐	☐
Coughing up blood	☐	☐
Wheezing	☐	☐

	Yes	No
Intestinal:		
Blood in stool	☐	☐
Constipation	☐	☐
Abdominal pain	☐	☐
Abdominal bloating	☐	☐
Diarrhea	☐	☐
Blood/growths:		
Bleeding from gums	☐	☐
Swollen lymph nodes	☐	☐
Breast lump or pain	☐	☐
Lump or mass elsewhere	☐	☐
Skin:		
Non-healing sore(s)	☐	☐
Changing mole(s)	☐	☐
Gynecologic/urinary:		
Irregular or heavy periods	☐	☐
Bleeding after menopause	☐	☐
Blood in urine	☐	☐
Pain with periods	☐	☐
Pain with intercourse	☐	☐
Unusual vaginal discharge	☐	☐

	Yes	No
Neurologic/psychiatric:		
Loss of memory	☐	☐
Weakness in limbs	☐	☐
Dizziness or passing out	☐	☐
Numbness or tingling	☐	☐
Anxiety or panic attacks	☐	☐
Feeling depressed or hopeless	☐	☐
Little interest in doing things	☐	☐
Joints, bones, and muscles:		
Muscle or bone pain	☐	☐
Painful Joints	☐	☐
Swollen ankles	☐	☐
Glands/endocrine:		
Thirsty all the time	☐	☐
Can't stand heat or cold	☐	☐
Do you have any other health concerns that your provider should know about today? If yes, please explain:	☐	☐

Completed by:______________________________ Date:____________________

(Patient signature)

Thank you for filling this out!

Reviewed by:

PHYSICIAN SIGNATURE	PRINTED NAME	PAGER	UPIN	DATE	TIME

PT.NO

NAME

DOB

UW Medicine
Harborview Medical Center – UW Medical Center
University of Washington Physicians
Seattle, Washington

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