

Women's Health Care – Gynecologic 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.

Patient name: _____ Patient age: _____ Today's date: _____

You are scheduled for a gynecologic annual.

This will focus on gynecologic concerns and breast evaluation. It may also include some discussion of osteoporosis.

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 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. |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Hospital stays, surgeries, or deliveries? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Medical care from doctors outside UWMC? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | New medical conditions? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Changes in job or living situation? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Changes in family's medical history? _____ |

Gynecologic Update: (Please check appropriate box for each item below)

If premenopausal:

Menses: every _____ days
 Regular Irregular
flow _____ days
 Light Moderate Heavy

If postmenopausal:

Date of last menses _____

Any bleeding since menopause?

Yes No

(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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Have you had a new sexual partner in the past year?

Yes No

Habits

Any tobacco use? Yes, _____ per day No
Any alcohol use? Yes, _____ per week No
Any illicit or street drugs? Yes, types _____ No

Recent Problems

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

| | Yes | No | | Yes | No | | Yes | No |
|-------------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|
| <u>General:</u> | | | <u>Intestinal:</u> | | | <u>Neurologic/psychiatric:</u> | | |
| Weight change without trying | <input type="checkbox"/> | <input type="checkbox"/> | Blood in stool | <input type="checkbox"/> | <input type="checkbox"/> | Loss of memory | <input type="checkbox"/> | <input type="checkbox"/> |
| Unusual fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | <input type="checkbox"/> | Weakness in limbs | <input type="checkbox"/> | <input type="checkbox"/> |
| Fevers | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness or passing out | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of appetite | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal bloating | <input type="checkbox"/> | <input type="checkbox"/> | Numbness or tingling | <input type="checkbox"/> | <input type="checkbox"/> |
| Awakening due to pain | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety or panic attacks | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Depression or blue moods | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Head/eyes/ears/throat:</u> | | | <u>Glands/Lumps</u> | | | <u>Joints, bones, and muscles:</u> | | |
| Changes in your eyesight | <input type="checkbox"/> | <input type="checkbox"/> | Swollen lymph nodes | <input type="checkbox"/> | <input type="checkbox"/> | Muscle or bone pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Hoarse voice | <input type="checkbox"/> | <input type="checkbox"/> | Breast lump or pain | <input type="checkbox"/> | <input type="checkbox"/> | Painful joints | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty swallowing | <input type="checkbox"/> | <input type="checkbox"/> | Lump or mass elsewhere | <input type="checkbox"/> | <input type="checkbox"/> | Swollen ankles | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty hearing | <input type="checkbox"/> | <input type="checkbox"/> | _____ describe/location | | | | | |
| Bleeding from gums | <input type="checkbox"/> | <input type="checkbox"/> | <u>Skin:</u> | | | <u>Endocrine:</u> | | |
| | | | Non-healing sore(s) | <input type="checkbox"/> | <input type="checkbox"/> | Thirsty all the time | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Changing mole(s) | <input type="checkbox"/> | <input type="checkbox"/> | Can't stand heat or cold | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Heart:</u> | | | <u>Gynecologic/urinary:</u> | | | Do you have any other health concerns that your provider should know about today? If yes, please explain: <input type="checkbox"/> <input type="checkbox"/> | | |
| Palpitation | <input type="checkbox"/> | <input type="checkbox"/> | Irregular periods | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Chest pain | <input type="checkbox"/> | <input type="checkbox"/> | Heavy periods | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding after menopause | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| <u>Lungs:</u> | | | Blood in urine | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | Pain with periods | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Cough | <input type="checkbox"/> | <input type="checkbox"/> | Pain with intercourse | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Coughing up blood | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| Wheezing | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |

Completed by: _____

(Patient signature)

Thank you for filling this out! PLEASE STOP HERE

Reviewed by Provider: _____

| | | | | | |
|---------------------|------------|-------|------|------|------|
| PHYSICIAN SIGNATURE | PRINT 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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