

## 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.                  |
|--------------------------|--------------------------|---|
| <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? _____      |

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

- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke? If yes, indicate amount _____         |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you consider your diet to be healthy?            |
| <input type="checkbox"/> | <input type="checkbox"/> | 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

**WHCC PREVENTIVE VISIT HEALTH UPDATE**



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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		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"/>
						Feeling depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>
<u>Head/eyes/ears/throat:</u>			<u>Blood/growths:</u>			Little interest in doing things	<input type="checkbox"/>	<input type="checkbox"/>
Changes in your eyesight	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding from gums	<input type="checkbox"/>	<input type="checkbox"/>	<u>Joints, bones, and muscles:</u>		
Hoarse voice	<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"/>
Difficulty swallowing	<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 hearing	<input type="checkbox"/>	<input type="checkbox"/>	Lump or mass elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>
<u>Heart:</u>			<u>Skin:</u>			<u>Glands/endocrine:</u>		
Palpitation	<input type="checkbox"/>	<input type="checkbox"/>	Non-healing sore(s)	<input type="checkbox"/>	<input type="checkbox"/>	Thirsty all the time	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<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"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>
<u>Lungs:</u>			Irregular or heavy periods	<input type="checkbox"/>	<input type="checkbox"/>			
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding after menopause	<input type="checkbox"/>	<input type="checkbox"/>			
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>			
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	Pain with periods	<input type="checkbox"/>	<input type="checkbox"/>			
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Pain with intercourse	<input type="checkbox"/>	<input type="checkbox"/>			
			Unusual vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>			

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient signature)

Thank you for filling this out!

Reviewed by:

PHYSICIAN SIGNATURE	PRINTED NAME	PAGER	UPIN	DATE	TIME
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PT.NO

NAME

DOB

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

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