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.
☐	☐	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? ______________________________

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

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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
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	☐	☐
Bleeding from gums	☐	☐
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	☐	☐
Glands/Lumps		
Swollen lymph nodes	☐	☐
Breast lump or pain	☐	☐
Lump or mass elsewhere	☐	☐
____________________ describe/location		
Skin:		
Non-healing sore(s)	☐	☐
Changing mole(s)	☐	☐
Gynecologic/urinary:		
Irregular periods	☐	☐
Heavy periods	☐	☐
Bleeding after menopause	☐	☐
Blood in urine	☐	☐
Pain with periods	☐	☐
Pain with intercourse	☐	☐

	Yes	No
Neurologic/psychiatric:		
Loss of memory	☐	☐
Weakness in limbs	☐	☐
Dizziness or passing out	☐	☐
Numbness or tingling	☐	☐
Anxiety or panic attacks	☐	☐
Depression or blue moods	☐	☐
Joints, bones, and muscles:		
Muscle or bone pain	☐	☐
Painful joints	☐	☐
Swollen ankles	☐	☐
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:____

(Patient signature)

Thank you for filling this out! **PLEASE STOP HERE**

Reviewed by Provider:______________________________________

PHYSICIAN SIGNATURE	PRINT NAME	PAGER	UPIN	DATE	TIME

PT.NO

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