Please Complete
Pages 1 & 2

27 Hospital Avenue, Danbury, CT 06810
(203) 798-0500

WOMEN'S HEALTH ASSOCIATES, P.C.
NEW PATIENT HISTORY & PHYSICAL

Patient Name:___________________________________ **ID#** ____________________ **Date:** _____/_______/________

☐ **New Patient** | ☐ **Consultation** **Referring MD:** ________________________ ☐ **Report Sent:** ____/____/_____

Primary Physician: __________________________ **Other Physician(s):** _____________________________________

CHIEF COMPLAINT (CC): (Why are you here?)
____

Age: ________ Last Menstrual Period: _____/_____/_____
Last PAP: ____/____(mo/yr) Last Mammogram: ____/____
Last Colonoscopy: ____/____ Last Bone Density: ____/____

CURRENT MEDICATIONS: ☐ **None**
____
____

ALLERGIES / DRUG SENSITIVITIES: ☐ **None**
____

PAST HISTORY (PH): ☐ **Non-Contributory**

Surgeries:____
Illness(es):____
Injuries:____
Pregnancies (#): Full Term: _____ Premature: _____ Miscarriages: _____ Abortions: _____ Cesarean Sections: _____

Do You Have Any Problems With Your Marriage, Spouse, or Sexual Partner You Would Like to Discuss? ☐ No ☐ Yes
Have You Ever Been Told Your PAP Smear Was Abnormal? ☐ No ☐ Yes
Do You Have Any Vaginal Discharge, Itching, Burning, or Odor? ☐ No ☐ Yes
Have You Ever Been Treated For a Sexually Transmitted Disease (Gonorrhea, Chlamydia, Herpes, Warts)? ☐ No ☐ Yes

Date of Most Recent Pregnancy: _____/_____/_________
Age When Your Periods Began: _______ (yrs)
Days From the Start of One Period to the Next: _____ (days)
Average Length of Your Periods: ______ (days)
Are You Having Trouble Getting Pregnant? ☐ No ☐ Yes

Are Your Periods Heavy or Painful? ☐ No ☐ Yes
Do You Spot or Bleed Between Periods? ☐ No ☐ Yes
Do You Have Bleeding or Pain With Sex? ☐ No ☐ Yes
Do You Have Discharge from Your Nipples? ☐ No ☐ Yes
Do You Leak Urine When You Sneeze? ☐ No ☐ Yes

FAMILY HISTORY (FH): ☐ **Non-Contributory**

Mother: ☐ Living ☐ Deceased Cause____
Father: ☐ Living ☐ Deceased Cause____
Siblings: Number Living ____ Number Deceased _____ Cause(s) _______________________________

FAMILY MEDICAL PROBLEMS:

☐ Diabetes ______________________ ☐ Heart Disease __________________ ☐ High Cholesterol ________________
☐ Hypertension ___________________ ☐ Breast Cancer __________________ ☐ Other Cancer ___________________
☐ Osteoporosis ___________________ ☐ Genetic Diseases _______________ ☐ Other _________________________

SOCIAL HISTORY (SH): ☐ **Non-Contributory**

Do You Smoke? ☐ No ☐ Yes Packs per Day: _________
Consume Alcohol / Drugs? ☐ No ☐ Yes Explain: ____
Experience Violence at Home? ☐No ☐Yes Explain: ____
Do You Exercise Regularly? ☐ No ☐ Yes Explain: ____
Present Birth Control Method: ☐ Birth Control Pills ☐ Condoms ☐ IUD ☐ Diaphragm ☐ Other_________________

PLEASE CHECK ALL THAT HAVE OCCURRED DURING THE LAST SIX MONTHS:

REVIEW OF SYSTEMS (ROS)**:**

System					
1. General:	☐ Weight Loss	☐ Weight Gain	☐ Fever	☐ Fatigue	☐ **Negative**
	☐ Headaches		☐ Other____________		
2. Eyes	☐ Vision Change	☐ Glasses/Contacts	☐ Blurring	☐ Glaucoma	☐ **Negative**
			☐ Other____________		
3. Ear, Nose, & Throat	☐ Nosebleeds	☐ Sinusitis	☐ Ringing	☐ Ear Aches	☐ **Negative**
	☐ Swollen Glands	☐ Voice Change	☐ Sores	☐ Other ____________	
4. Cardiovascular	☐ Chest pain	☐ Shortness of Breath	☐ Palpitations		☐ **Negative**
	☐ Leg Swelling		☐ Other ____________		
5. Respiratory	☐ Wheezing	☐ Emphysema	☐ Asthma	☐ Cough	☐ **Negative**
	☐ Spitting Up Blood		☐ Other ____________		
6. Digestive	☐ Bloody Stool	☐ Appetite Change	☐ Diarrhea	☐ Pain	☐ **Negative**
	☐ Constipation	☐ Nausea & Vomiting	☐ Other ____________		
7. Genitourinary	☐ Blood in Urine	☐ Frequent Urination	☐ Burning	☐ Incontinence	☐ **Negative**
	☐ Abn. Periods	☐ Change in Libido	☐ Other ____________		
8. Musculoskeletal	☐ Joint Swelling	☐ Muscle Weakness	☐ Joint Pain	☐ Arthritis	☐ **Negative**
			☐ Other ____________		
9. Skin / Breasts	☐ Varicose Veins	☐ Lumps	☐ Pain	☐ Rash	☐ **Negative**
	☐ Itching	☐ Nipple Discharge	☐ Other ____________		
10. Neurological	☐ Numbness	☐ Seizures	☐ Fainting	☐ Dizziness	☐ **Negative**
			☐ Other ____________		
11. Psychiatric	☐ Depression	☐ Insomnia	☐ Anxiety	☐ Crying	☐ **Negative**
	☐ Confusion	☐ Memory Loss	☐ Other ____________		
12. Hormones	☐ High Thyroid	☐ Low Thyroid	☐ Diabetes	☐ Hot Flashes	☐ **Negative**
	☐ Cold Intolerance	☐ Thirst	☐ Other ____________		
13. Blood Diseases	☐ Bruising	☐ Excessive Bleeding	☐ Anemia	☐ Phlebitis	☐ **Negative**
	☐ Swollen Glands	☐ Poor Healing	☐ Other ____________		
14. Allergic Problems (see first page)					

PLEASE LEAVE BLANK

TOTAL NUMBER SYSTEMS REVIEWED: __________