FEMALE PATIENT INFORMATION

Name:____ **Date of Birth:**____________

Last **First** **Middle** **Date:**_____________

Address:____

City:______________________________ State:________ Zip Code:_________________

Phone Numbers: Home:______________________ Cell:___________________________

E-mail Address (for office use only will not be shared):_____________________________________

Patient employed by:____

Occupation:____

Business Address:____

Business Phone:____

In case of emergency, whom should we notify:______________________________________

Emergency Phone Numbers:____

Marital Status: (Please circle) Married Divorced Single Widow Living with significant other

Soc. Sec, # (required to order pellets):____________________

Is it ok to leave a message with lab work results on your voice-mail: (please circle) Yes No

What phone number would you like us to call with lab results and/or appointment reminders?

Phone #: ___________________________________

*****Payment is due at time of service.*****

Payment types accepted: Cash, Check, Visa, Mastercard, Discover
and American Express

What is your primary health concern or reason for this appointment ?

____

____

HEALTH HISTORY

1. Are you sexually active? ☐ Yes ☐ No
2. Have you been sexually active? ☐ Yes ☐ No
3. Do you have pain with intercourse? ☐ Yes ☐ No
4. Are you now or have you in the past used contraception? ☐ Yes ☐ No

   If yes, what form:____
5. Dates of last pap smear:____
6. Have you ever had abnormal pap smears? ☐ Yes ☐ No

   If yes, how was it treated? Please check below:

   ☐ Repeated Pap Smear ☐ Colposcopy ☐ Laser Surgery ☐ Cone Biopsy

   ☐ Cryosurgery (freezing) ☐ Hysterectomy ☐ Loop incision
7. Have you had a mammogram? ☐ Yes ☐ No

   If yes, was it normal? ☐ Yes ☐ No

   Date of last mammogram:____
8. Do you have any breast lumps, tenderness or discharge? ☐ Yes ☐ No
9. Do you have any PMS symptoms? ☐ Yes ☐ No

   If yes, any treatment?____
10. Do you have any hot flashes or menopausal symptoms? ☐ Yes ☐ No
11. Do you have any uterine anomalies? ☐ Yes ☐ No
12. If you no longer have periods, please state reason:_________________________
13. Are your periods regular? ☐ Yes ☐ No
14. Do you have any bleeding between periods? ☐ Yes ☐ No
15. Do you have any cramping with your periods? ☐ Yes ☐ No

    If yes, circle one: mild moderate severe
16. Medicine taken for cramps?____
17. Do you have problems leaking urine? ☐ Yes ☐ No

18. Do you have:

Fatigue?	☐ Yes	☐ No
Decrease of memory?	☐ Yes	☐ No
Decrease of energy level?	☐ Yes	☐ No
Decrease of sexual drive?	☐ Yes	☐ No

19. Do you suffer from:

Anxiety?	☐ Yes	☐ No
Irritability?	☐ Yes	☐ No
Mood swings?	☐ Yes	☐ No
Migraines?	☐ Yes	☐ No

20. How have you dealt with these symptoms?

____

____

____

____

21. Is your sex drive the same as it was five years ago? ☐ Yes ☐ No

Describe:____

22. List any other sexual dysfunctions:

____

____

____

23. Have you experienced weight gain in the last one - two years? ☐ Yes ☐ No

If yes, why?____

24. Have you lost greater than 10 pounds in less than a month? ☐ Yes ☐ No

If yes, why?____

25. List current medications:

____

____

____

26. How often does your doctor recommend that you have a Pap smear?

____

27. How often does your doctor recommend that you have a mammogram?

____

PAST MEDICAL HISTORY

1. Do you have diabetes? ☐ Yes ☐ No
2. Do you have/had hypertension? ☐ Yes ☐ No
3. Do you have heart disease? ☐ Yes ☐ No
4. Do you have a heart murmur? ☐ Yes ☐ No
5. Do you have/had kidney disease? ☐ Yes ☐ No
6. Have you ever been treated for psychiatric problems? ☐ Yes ☐ No
7. Have you ever had rheumatic fever? ☐ Yes ☐ No
8. Do you have mitral valve prolapse? ☐ Yes ☐ No
9. Have you ever had a urinary tract infection? ☐ Yes ☐ No
10. Have you ever had hepatitis/liver disease? ☐ Yes ☐ No
11. Have you ever had varicosities/phlebitis/blood clot? ☐ Yes ☐ No
12. Do you have any thyroid problems? ☐ Yes ☐ No
13. Have you had any major accidents? ☐ Yes ☐ No
14. Have you ever had any blood transfusions? ☐ Yes ☐ No
15. Do you have asthma/lung disease? ☐ Yes ☐ No
16. Do you have lupus, Scleroderma or similar diseases? ☐ Yes ☐ No

    If yes, please describe:____
17. Do you have arthritis? ☐ Yes ☐ No

    If yes, what type:____
18. Do you have any Drug Allergies? ☐ Yes ☐ No

    If yes, please list:____

19. List any surgeries:

____

____

____

20. List any other operations/hospitalizations (include year & reason):

____

____

____

21. Have you had any anesthesia complications? ☐ Yes ☐ No

If yes, please list:____

\22. Have you ever been anemic? ☐ Yes ☐ No

23. Do you have an Internist or Family Doctor? ☐ Yes ☐ No

If yes, please list name and phone number:____________________________________

24. Have you had your cholesterol checked? ☐ Yes ☐ No

If yes, date last checked:____

Was it normal? ☐ Yes ☐ No

SOCIAL HISTORY

1. Do you smoke cigarettes? ☐ Yes ☐ No

If yes, number per day?________________________ Number of years?______________

2. Do you drink alcohol? ☐ Yes ☐ No

If yes, how much per day?____

FAMILY HISTORY

1. Do you have a family history of breast cancer?☐ Yes ☐ No

If yes, whom?____

2. Do you have a family history of colon cancer? ☐ Yes ☐ No

   If yes, whom?____

3. Do you have a family history of ovarian cancer? ☐ Yes ☐ No

   If yes, whom?____

4. Do you have a family history of osteoporosis? ☐ Yes ☐ No

   If yes, whom?____

5. Do you have a family history of diabetes? ☐ Yes ☐ No

   If yes, whom?____

6. Do you have a family history of hypertension? ☐ Yes ☐ No

   If yes, whom?____

7. Do you have a family history of heart disease? ☐ Yes ☐ No

   If yes, whom?____

8. Do you have a family history of kidney disease? ☐ Yes ☐ No

   If yes, whom?____

Hebron Office: 2940 Hebron Park Dr. Suite 301, Hebron, KY 41048

Oakley Office: 3215 Madison Rd., Cincinnati, OH 45209