

PATIENT HISTORY

The Woman's Group

1615 Hospital Parkway • Suite 204 • Bedford, Texas 76022
 Phone: (817) 684-5002
 Fax: (817) 684-5150

Linda A. Prentice, M.D.
 Stephanie Carson-Henderson, M.D.
 Barbara Webster, D.O.
 Stephanie Taylor, M.D.
 Emily Emmet, M.D.

PATIENT: _____ **BIRTH DATE:** _____

CONSTITUTIONAL	YES	NO	UNSURE	GENITOURINARY CON'T	YES	NO	UNSURE
WEIGHT LOSS				INVOLUNTARY / UNINTENDED URINE LOSS			
WEIGHT GAIN				URINE LOSS WHEN COUGHING OR LIFTING			
FATIGUE				ABNORMAL BLEEDING			
FEVER				PAINFUL PERIODS			
CHANGE IN HEIGHT				PREMENSTRUAL SYNDROME (PMS)			
EYES				PAINFUL INTERCOURSE			
DOUBLE VISION				FIBROIDS			
SPOTS BEFORE EYES				INFERTILITY			
VISION CHANGES				DES EXPOSURE			
GLASSES/CONTACTS				ABNORMAL VAGINAL DISCHARGE			
EAR, NOSE, THROAT				MUSCULOSKELETAL			
EAR ACHES				MUSCLE WEAKNESS			
RINGING IN EARS				MUSCLE OR JOINT PAIN			
HEARING PROBLEMS				SKIN			
SINUS PROBLEMS				RASH			
SORE THROAT				SORES			
MOUTH SORES				DRY SKIN			
DENTAL PROBLEMS				MOLES			
CARDIOVASCULAR				BREAST			
PAINFUL BREATHING				PAIN IN BREAST			
CHEST PAIN				NIPPLE DISCHARGE			
DIFFICULTY BREATHING ON EXERTION				LUMPS			
SWELLING OF LEGS				NEUROLOGIC			
RAPID OR IRREGULAR HEART RATE				SEVERE MEMORY PROBLEMS			
RESPIRATORY				SEIZURES			
WHEEZING				NUMBNESS			
SPITTING UP BLOOD				DIZZINESS			
SHORTNESS OF BREATH				FREQUENT OR SEVERE HEADACHES			
CHRONIC COUGH				TROUBLE WALKING			
GASTROINTESTINAL				PSYCHIATRIC			
FREQUENT DIARRHEA				DEPRESSION OR FREQUENT CRYING			
BLOODY STOOL				SEVERE ANXIETY			
NAUSEA/ VOMITING/ INDIGESTION				ENDOCRINE			
CONSTIPATION				HAIR LOSS			
INVOLUNTARY LOSS OF GAS OR STOOL				HEAT/ COLD INTOLERANCE			
GENITOURINARY				ABNORMAL THIRST			
BLOOD IN URINE				HOT FLASHES			
PAIN WITH URINATION				HEMATOLOGIC/ LYMPHATIC			
FREQUENT URINATION				CUTS DO NOT STOP BLEEDING			
INCOMPLETE EMPTYING				FREQUENT BRUISES			
				ENLARGED LYMPH NODES (GLANDS)			

PATIENT: _____

LIST ANY MEDICATION ALLERGIES:	REVIEWED BY:	DATE REVIEWED:
--------------------------------	--------------	----------------

GYNECOLOGIC HISTORY

FIRST DAY OF LAST PERIOD:	ANY RECENT CHANGES IN PERIOD?
ARE YOU SEXUALLY ACTIVE?	HAVE YOU EVER HAD SEX?
NUMBER OF SEXUAL PARTNERS (LIFETIME)	SEXUAL PARTNERS ARE: <input type="checkbox"/> MEN <input type="checkbox"/> WOMEN <input type="checkbox"/> BOTH
PRESENT METHOD OF BIRTH CONTROL:	PATIENT COMMENTS:

OBSTETRIC HISTORY

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS		LIVE BIRTHS		LIVING CHILDREN	

PERSONAL PROFILE

SEXUAL ORIENTATION: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual
MARITAL STATUS: <input type="checkbox"/> Married <input type="checkbox"/> Living with Partner <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
NUMBER OF LIVING CHILDREN:
CURRENT OR MOST RECENT JOB:

PERSONAL PAST HISTORY OF ILLNESSES

(If you have never had the illness, do not mark anything)

MAJOR ILLNESSES	YES	NO	UNSURE	MAJOR ILLNESSES	YES	NO	UNSURE
ASTHMA				CHICKEN POX			
PNEUMONIA/ LUNG DISEASE				HIATAL HERNIA/ ULCERS/ REFLUX			
KIDNEY INFECTIONS/ STONES				DEPRESSION/ ANXIETY			
TUBERCULOSIS				CANCER			
SEXUALLY TRANSMITTED DISEASE				SEIZURES/ CONVULSIONS/ EPILEPSY			
HIV/ AIDS				ANEMIA			
HEART ATTACK/ PROBLEMS				BLOOD TRANSFUSIONS			
DIABETES				BOWEL PROBLEMS			
HIGH BLOOD PRESSURE				ARTHRITIS/ JOINT PAIN/ BACK PROBLEMS			
STROKE				GLAUCOMA			
RHEUMATIC FEVER				CATARACTS			
BLOOD CLOTS IN LUNGS OR LEGS				THYROID DISEASE			
EATING DISORDERS				BROKEN BONES			
COLLAGEN VASCULAR DISEASE (LUPUS)				HEPATITIS/ YELLOW JAUNDICE/ LIVER DISEASE			

SOCIAL HISTORY

DO YOU SMOKE?	IF YES, PACKS PER DAY:	YEARS:	YES	NO
ALCOHOL: DRINKS PER DAY:	DRINKS PER WEEK:			
RECREATIONAL DRUG USE:	IF YES, HOW LONG SINCE LAST USE:			