Office Use:
Height: _____
Weight: _____

WOMEN'S WELLNESS CENTER

Obstetrics • Gynecology • Infertility • Osteopathy

Health History Update

Name: _____ Date: _____ Phone: _____

Address: _____

Alternate Phone Number: _____ Email: _____

Emergency Contact Name & Phone Number: _____

Insurance: _____ Policy Number: _____ Group Number: _____

Current Employer: _____ Pharmacy: _____

Allergies: _____

Current Medications: _____

Please list any illnesses, injuries, or new diagnoses you or your immediate family have had in the past year: (include dates)

_____

_____

Please list any surgeries or hospitalizations you have had in the past year: (include date & hospital)

_____

Please list date of last:

Colonoscopy: _____ Bone Density: _____ Mammogram: _____

Flu Vaccine: _____ Tdap Vaccine: _____ Pap Smear: _____

Last menstrual period: _____ (if applicable)

Are you Pregnant? ☐ Yes ☐ No ☐ Maybe

Have you been pregnant and delivered elsewhere? ☐ Yes ☐ No If so, where? _____

Do you smoke? ☐ Yes ☐ No ☐ Recently quit (date: _____)

If yes, how much per day? ☐ ¼ pack ☐ ½ pack ☐ 1 pack ☐ Other: _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many drinks per week? _____ Month? _____

Signature: _____ Date: _____

SARA CASTELLANOS, D.O., FACOOG, OBGYN ELYSE BROCK, M.D., FACOG, OB/GYN

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Symptoms/Conditions

Please check what symptoms you currently have or have had in the past year.

General
□ Fatigue
□ Recurrent fever
□ Weight Gain _____ pounds
□ Weight Loss _____ pounds

Skin
□ Changes in moles
□ Rashes

Ear, Nose, Mouth, and Throat
□ Hearing loss
□ Earache
□ Sinus problems
□ Recurrent sore throat
□ Snoring
□ Dry mouth
□ Mouth ulcer

Respiratory
□ Shortness of breath
□ Persistent Cough
□ Sputum
□ Wheezing

Cardiovascular
□ Chest pain
□ Irregular heartbeat
□ High blood pressure

Gastrointestinal
□ Heartburn
□ Difficulty swallowing
□ Nausea
□ Vomiting
□ Abdominal pain
□ Bowel changes
□ Diarrhea
□ Constipation
□ Rectal bleeding

Genito-Urinary
□ Blood in the urine
□ Abnormal bleeding
□ Flank pain
□ Trouble urinating
□ Lack of bladder control
□ Rash
□ Lesion
□ Vaginal discharge
□ Vaginal odor
□ Vaginal itching/irritation

Endocrine
□ Irritability
□ Tension
□ Anxiety
□ Depression
□ Breast pain/tenderness
□ Bloating
□ Overwhelmed feeling
□ Hot flashes
□ Night sweats
□ Vaginal dryness
□ Impaired memory
□ Impaired concentration
□ Decreased libido
□ Orgasmic dysfunction
□ Pain with intercourse

Muscoskeletal
□ Muscle aches
□ Muscle weakness
□ Joint pain
□ Back pain

Neurological
□ Headaches
□ Dizziness
□ Loss of consciousness
□ Weakness
□ Numbness
□ Seizures

Psychological
□ Depression
□ Alcoholism
□ Sleep disturbances

Lymphatic
□ Swollen glands
□ Bruise easily

Immunolgoic
□ Runny nose
□ Itching
□ Hives
□ Frequent sneezing

☐ NONE

Signature: _____ Date: _____

Interpreter Signature: _____ Date: _____

Please complete all questions. Do not leave any questions blank. For each question, mark the box accurately describes how often you experience your symptoms.

Do you leak urine (even small drops), wet yourself or wet your pad or undergarments…	None of the time 0	Rarely 1	Once in a while 2	Often 3	Most of the time 4	All of the time 5
1. When you cough, laugh, or sneeze?	☐	☐	☐	☐	☐	☐
2. When you bend down or lift something up?	☐	☐	☐	☐	☐	☐
3. When you walk quickly, jog, or exercise?	☐	☐	☐	☐	☐	☐
			Stress Incontinence Subscale Score Total:			
4. When you are undressing to use the toilet?	☐	☐	☐	☐	☐	☐
5. Do you get such a strong and uncomfortable need to urinate that you leak urine (even small drops) or wet yourself before reaching the toilet?	☐	☐	☐	☐	☐	☐
6. Do you have to rush to the bathroom because you get a sudden, strong need to urinate?	☐	☐	☐	☐	☐	☐
			Urge Incontinence Subscale Score Total:			

Recent research indicates that 1 out of 4 women over the age of 18 experience some type of bladder leakage. Leakage typically affects 30-50% of childbearing women by age 40.