Santé

Comprehensive Women's Healthcare

NAME: ____________________

DOB: ____________________

Were you referred by anyone? ____________________

Name you like to be called: ____________________

Employer: ____________________

Occupation: ____________________

DATE: ____________________

PHONE NUMBER: ____________________

WORK ____________________

CELL ____________________

Can we contact you at work? ❑ YES ❑ NO

Is this a private number where we can leave a message? ❑ YES ❑ NO

Reason for Visit: ____________________

What is the 1st day of your last menstrual period? __________ Method of Birth Control: __________

Allergies: ____________________

Since your last examination, have you had any problems with:

	Yes	No
Your menstrual cycles?	❑	❑
Irregular bleeding?	❑	❑
Cramps w/period?	❑	❑
Abnormal vaginal discharge?	❑	❑
Pelvic/abdominal pain?	❑	❑
Breasts?	❑	❑
Change in bowel habits?	❑	❑
Colonoscopy?	❑	❑
Any urinary problems, burning frequency?	❑	❑
Physical/mental/sexual abuse?	❑	❑

Since your last visit, have you had any:

Medical problems	❑	❑
Sexual problems?	❑	❑
Dental problems?	❑	❑
Surgeries?	❑	❑
Change in family history?	❑	❑

Partners: ❑ Male ❑ Female ❑ Both

Have you or anyone in your family ever had any of these cancers:

	Personal	Family
Breast	❑	❑ __________
Ovarian	❑	❑ __________
Colon	❑	❑ __________
Endometrial	❑	❑ __________
Cervical	❑	❑ __________

	Yes	No	How long per day/per wk
Do you smoke?	❑	❑	__________
Do you drink alcohol?	❑	❑	__________
Do you drink caffeine?	❑	❑	__________
Do you get calcium in your diet?	❑	❑	__________
Do you use marijuana, cocaine, or any other drugs?	❑	❑	__________
Do you perform self breast exams?	❑	❑	__________
How often do you exercise?			__________

Are you planning to conceive? ❑ YES ❑ NO When __________

Seat Belt use ❑ YES ❑ NO

HIV Risk ❑ YES ❑ NO

Are there any problems or issues you would like to discuss? ____________________

What prescriptions or over-the-counter medications do you take on a regular basis (include vitamins):

____

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____

____

STAFF USE ONLY

❑ Medication List Reviewed

❑ Problem List Reviewed

❑ Reviewed Initial Intake Form Dated __________

____

Provider

01/06