

# Santé

## Comprehensive Women's Healthcare

Date \_\_\_\_\_ Email \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status:  
 Single  Married  Widowed  Divorced  
 Preferred name to be called \_\_\_\_\_  
 Were you referred by anyone \_\_\_\_\_ Pronouns:  
 Employer \_\_\_\_\_ She/Her, He/Him, They/Them  
 Does your insurance require you to use a specific lab?  Yes  No \_\_\_\_\_

**ALLERGIES/SENSITIVITIES AND REACTIONS:** \_\_\_\_\_

**CURRENT MEDICATIONS:** *Include prescribed, over-the-counter, folic acid or vitamins, herbal remedies or supplements, inhalers, etc. use back if needed*

Name of Medication	Strength/Dose	Frequency/Taken	Reason for Taking

Family history of major illnesses/cancer, including breast, ovarian, colon, endometrial?  Yes  No

Details: \_\_\_\_\_

You or family member has problems with anesthesia  Yes  No

Details: \_\_\_\_\_

**HAVE YOU HAD:**

Colonoscopy  Yes  No When \_\_\_\_\_ Results \_\_\_\_\_

Mammogram  Yes  No When \_\_\_\_\_ Results \_\_\_\_\_

Pap  Yes  No When \_\_\_\_\_ Results \_\_\_\_\_

Bone Density  Yes  No When \_\_\_\_\_ Results \_\_\_\_\_

Sexually Active  Yes  No  Male  Female  Both  Other

Pregnancy in future  Yes  No

Birth control method if applicable \_\_\_\_\_

Any concerns with  Heavy bleeding  Irregular bleeding

Hot flashes  Night sweats

Mood changes  Post menopausal bleeding

**Last Menstrual Period** or age of menopause \_\_\_\_\_

Any changes in medical history, surgeries, family history?

Details: \_\_\_\_\_

Reason for visit? \_\_\_\_\_

**PLEASE CHECK BELOW ANY CURRENT SYMPTOMS YOU HAVE**

- |   |   |  |  |   |
|---|---|--|--|---|
| <input type="checkbox"/> <b>None</b><br><b>GENERAL</b><br><input type="checkbox"/> Fever<br><input type="checkbox"/> Chills<br><input type="checkbox"/> Sweats<br><input type="checkbox"/> Weight loss<br><input type="checkbox"/> Weight gain<br><input type="checkbox"/> Poor appetite<br><input type="checkbox"/> Fatigue<br><b>HEART</b><br><input type="checkbox"/> Lightheadedness<br><input type="checkbox"/> Palpitations<br><input type="checkbox"/> Swelling of legs/ankles<br><input type="checkbox"/> Chest Pain<br><b>LUNGS</b><br><input type="checkbox"/> Cough<br><input type="checkbox"/> Shortness of breath with or without activity | <b>JOINTS/MUSCLES</b><br><input type="checkbox"/> Stiff joints<br><input type="checkbox"/> Neck pain<br><input type="checkbox"/> Back pain<br><b>DIGESTION</b><br><input type="checkbox"/> Nausea<br><input type="checkbox"/> Vomiting<br><input type="checkbox"/> Change in bowel movements (frequency, size or shape)<br><input type="checkbox"/> Black stools<br><input type="checkbox"/> Blood in stools<br><input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Constipation<br><input type="checkbox"/> Abdominal pain | <b>BLADDER</b><br><input type="checkbox"/> Frequency<br><input type="checkbox"/> Painful urination<br><input type="checkbox"/> Blood in urine<br><input type="checkbox"/> Sudden urge to urinate<br><input type="checkbox"/> Slow stream<br><input type="checkbox"/> Incomplete emptying<br><input type="checkbox"/> Leaking urine<br><b>SKIN</b><br><input type="checkbox"/> Rash<br><input type="checkbox"/> New or unusual skin lesion<br><input type="checkbox"/> Changing mole<br><b>BREAST</b><br><input type="checkbox"/> Lump <input type="checkbox"/> Left <input type="checkbox"/> Right<br><input type="checkbox"/> Nipple <input type="checkbox"/> Left <input type="checkbox"/> Right discharge<br><input type="checkbox"/> Pain <input type="checkbox"/> Left <input type="checkbox"/> Right | <b>HORMONAL</b><br><input type="checkbox"/> Excessive urination<br><input type="checkbox"/> Excessive thirst<br><input type="checkbox"/> Fertility issues<br><input type="checkbox"/> Temperature intolerance<br><input type="checkbox"/> Difficulty sleeping<br><input type="checkbox"/> Hot flashes<br><input type="checkbox"/> Night sweats<br><input type="checkbox"/> Vaginal dryness<br><input type="checkbox"/> Pain with intercourse<br><b>BLOOD</b><br><input type="checkbox"/> Easy bruising<br><input type="checkbox"/> Excessive bleeding from nose/gums/cuts<br><input type="checkbox"/> Swollen lymph nodes<br><b>NEUROLOGIC</b><br><input type="checkbox"/> Headaches<br><input type="checkbox"/> Seizures<br><input type="checkbox"/> Numbness | <b>MOOD</b><br><input type="checkbox"/> Eating disorder<br><input type="checkbox"/> Anxiety<br><input type="checkbox"/> Mood swings<br><input type="checkbox"/> Depression<br>During the past month, have you often been bothered by feeling down, depressed, or hopeless <input type="checkbox"/> Yes <input type="checkbox"/> No<br>During the past month, have you often been bothered by little interest or pleasure in doing things <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|---|--|--|---|

Do you feel safe?  Yes  No

Do you smoke?  Yes  No  
 How much? \_\_\_\_\_

Do you drink alcohol?  Yes  No  
 How many times? \_\_\_\_\_

Have you had 4 or more drinks per day?  Yes  No

How many times have you used recreational drugs in the past month or used prescription medication for non-medical reasons \_\_\_\_\_

Are you in recovery for alcohol or substance abuse?  Yes  No

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**