Seattle Women's Clinic | **Bellevue Women's Clinic**

NAME: ______________________________ DATE: ____________________

What health problems do you want to talk about when you are seen in the clinic? ____________________

____

What prescription medications do you presently take? (List doses and frequency) ____________________

____

____

What non-prescription medications or supplements do you take? (Herbal or other supplements) ____________________

____

Have there been any significant changes in your health since your last visit (ie. Surgeries, hospitalizations, other?)

____

Do you use tobacco? No _______ Yes ______ If yes, how much and how often ____________________

Do you drink alcohol? No _______ Yes ______ If yes, how much and how often ____________________

Recent GYN History:

When was the first day of your last period? ________________

What is your current form of contraception? ________________

What was the date of your last Pap smear? ________________

What was the date of your last Mammogram? ______________

Do you have any breast pain/tenderness? Yes ______ No ______

Do you have any nipple discharge? Yes ______ No _______

Current Menstrual Cycle:

Is Your Cycle Regular? Yes ______ No_____

Flow?
- ☐ Light
- ☐ Moderate
- ☐ Excessive

Symptoms: *Please mark an X in the box if any of the following apply to you now or in the past or never.*

Never	Now	Past	Gynecological
☐	☐	☐	Bleeding Between Periods
☐	☐	☐	Unusual Discharge
☐	☐	☐	STD Exposure
☐	☐	☐	Painful Periods
			Urinary
☐	☐	☐	Leaking Urine
☐	☐	☐	Frequent Infection
			Head, Eyes, Ears, Nose, Throat
☐	☐	☐	Dizziness
☐	☐	☐	Hearing Loss
☐	☐	☐	Problem With Vision
			Heart and Circulation
☐	☐	☐	Chest Pain
☐	☐	☐	Frequent Irregular Heart Beat
☐	☐	☐	Ankle Swelling
☐	☐	☐	Blood Clots
			Neuro
☐	☐	☐	Memory Loss
☐	☐	☐	Numbness/tingling
☐	☐	☐	Headaches

Never	Now	Past	Stomach/Intestinal
☐	☐	☐	Frequent Nausea/Vomiting
☐	☐	☐	Change in Bowel Habits
☐	☐	☐	Persistent Constipation
☐	☐	☐	Persistent Diarrhea
☐	☐	☐	Blood in Bowel Movements
			Lungs
☐	☐	☐	Chronic Cough
☐	☐	☐	Shortness of Breath
			Musculoskeletal
☐	☐	☐	Persistent Back Pain
☐	☐	☐	Joint pain
			Psychiatric
☐	☐	☐	Depression
☐	☐	☐	Anxiety
			General
☐	☐	☐	Severe Fatigue
☐	☐	☐	Unexplained Weight Gain/Loss
☐	☐	☐	Unexplained Hair loss

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(physician signature)

SWC-09 R5/04)