Women's Health
Connecticut

Women's Health Group
Member of Women's Health Connecticut

170 Hazard Avenue
Enfield, CT 06082
860-763-4001

NAME: ____DATE: __________________

REASON FOR VISIT ____

CURRENT HEALTH: (Recent Problems)

Yes No
___ ___ Severe headaches
___ ___ Easy bruising
___ ___ Chronic cough
___ ___ Swelling hands/feet
___ ___ Skin rashes/boils
___ ___ Frequent infections
___ ___ Change in: appetite/bowels
___ ___ Blood in: urine/bowels
___ ___ Pain with: urination
___ ___ Pain with: bowel movement
___ ___ Waking to urinate
___ ___ Accidental loss of urine
___ ___ Inability to stand heat/cold
___ ___ Other: _______________________
____

FAMILY HISTORY: (Please list paternal or maternal and relationship)

Yes No
___ ___ High Blood Pressure ________________________________
___ ___ Stroke ________________________________
___ ___ Heart Problem ________________________________
___ ___ Anemia ________________________________
___ ___ Blood/bleeding problem ________________________________
___ ___ Diabetes ________________________________
___ ___ Thyroid Problem ________________________________
___ ___ Kidney Problem ________________________________
___ ___ Cancer ________________________________
___ ___ Breast Cancer ________________________________
___ ___ Inherited Disorder ________________________________
___ ___ Birth Defects ________________________________
___ ___ Alcoholism ________________________________
___ ___ Emotional Disorder ________________________________
___ ___ Other: _________ ________________________________

PAST MEDICAL HISTORY:

Yes No
___ ___ Anemia
___ ___ Sickle Cell Trait/Disease
___ ___ Rheumatic Fever
___ ___ Heart Problem
___ ___ High Blood Pressure
___ ___ Stroke
___ ___ Leg Pain, Phlebitis
___ ___ High Cholesterol

Yes No
___ ___ Emotional Problem
___ ___ Cancer
___ ___ Epilepsy
___ ___ Migraines
___ ___ Hemorrhoids
___ ___ Severe Injury
___ ___ Frequent Nosebleeds
___ ___ Asthma

Yes No
___ ___ Arthritis
___ ___ Diabetes
___ ___ Thyroid Problem
___ ___ Kidney Problem
___ ___ Jaundice/Liver Problem
___ ___ Gall-Bladder Problem
___ ___ Bowel/Stomach Problem

HEALTH MAINTENANCE: do you…

Yes No
___ ___ Eat a balanced diet
___ ___ Exercise □ daily □ weekly □ occasionally □ rarely □ never Type: ____________________
___ ___ Do self - Breast Exam
___ ___ Have trouble with weight
___ ___ Have difficulty sleeping
___ ___ Smoke □ currently □quit □ never □ cigarettes □ cigars □ other ______________________ Frequency _______________
___ ___ Drink coffee/tea/colas
___ ___ Drink alcohol □ daily □ weekly □ occasionally □ rarely □ never □ Beer □ wine □ Hard liquor: How many _______ Per ________

ALLIERGIES:

____
____
____
____
____
____
____
____

MEDICATIONS

____
____
____
____
____
____
____
____

CURRENT FORM OF BIRTH CONTROL:
____
PRIMARY CARE PROVIDER:
____
LAST COLONOSCOPY:
____
LAST MAMMOGRAM:
____
LAST PAP:________________________

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SURGERY/HOSPITALIZATIONS:

Date	Hospital	Reason/Complications
__________	______________________________	____
__________	______________________________	____
__________	______________________________	____

REPRODUCTIVE HEALTH:

MENSTRUAL CYCLE

_______ Age when first period occurred

_______ Frequency: (First day of cycle to next cycle)

_____ Duration: (Number of days period lasts)

FLOW: _____ Heavy ____Moderate ____Light

PAIN: _____ Severe ____Moderate ____Light

Last Menstrual Period: ______________

CONTRACEPTIVE:__________________________________

Office use

S.A. ___________________________________

G ______ T______ P______ A______ L______

Do You have a History of :

Yes	No	
___	___	DES Exposure
___	___	Twins in Family
___	___	Breast Problems
___	___	Abnormal Pap Smears
___	___	Gonorrhea
___	___	Syphilis
___	___	Chlamydia
___	___	Warts
___	___	Herpes
___	___	HIV
___	___	Other sexually transmitted diseases

Do You Have Vaginal:

Yes	No	
___	___	Discharge
___	___	Odor
___	___	Itching
___	___	Burning
___	___	Irregular Bleeding

OCCUPATION:____

Pregnancy Record

Mo/Yr	Hospital	Sex	Wt	Weeks	Type (Vag/C-S)	Complications
______	______________________________	_____	_____	_____	__________	__________________________
______	______________________________	_____	_____	_____	__________	__________________________
______	______________________________	_____	_____	_____	__________	__________________________
______	______________________________	_____	_____	_____	__________	__________________________

Race: ____

Ethnicity: ______________________________________