ASHEVILLE WOMEN'S MEDICAL CENTER **Chart # _____**

A Comprehensive Health Care Questionnaire Date _____

Name_____ Date of Birth _____ Age_____
First Last Middle

Address_____
Street City State Zip

Phone Numbers (H) _____ (W) _____ Spouse or Support Person _____ Phone_____

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Pharmacy _____ Primary Care Physician _____

Height _____ Weight _____

Allergies: _____

Medications and Dose: (include over-the-counter and prescription drugs) _____

_____ _____

_____ _____

_____ _____

Supplements and Dose: _____

Vaccines: FLU ☐ YES ☐ NO If yes, date of last: _____

COVID ☐ YES ☐ NO If yes, dates: _____

GARDASIL / HPV ☐ YES ☐ NO If yes, dates: _____

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GYN HISTORY LMP date: _____ Sexually active ☐ YES ☐ NO Age of first menses _____

Current birth control_____ Age at menopause _____

DATE OF LAST: MAMMOGRAM _____ RESULT _____

COLONOSCOPY _____ RESULT _____

BONE DENSITY _____ RESULT _____

PAP SMEAR _____ RESULT _____

HIGH RISK HPV TEST _____ RESULT _____

History of abnormal pap smear ☐ YES ☐ NO; if yes please explain_____

DES Exposure ☐ YES ☐ NO

****

OBSTETRIC HISTORY Number of pregnancies _____ Number of children _____

Past pregnancies (dates of delivery)_____

History of Miscarriages or Abortion ☐ YES ☐ NO

FAMILY HISTORY: parents / grandparents / siblings

Breast Cancer ☐ YES ☐ NO relation: _____ Ovarian Cancer ☐ YES ☐ NO relation: _____

Colon Cancer ☐ YES ☐ NO relation: _____ Birth defects ☐ YES ☐ NO relation: _____

Diabetes ☐ YES ☐ NO relation: _____ High blood pressure ☐ YES ☐ NO relation: _____

Stroke ☐ YES ☐ NO relation: _____ Heart attack ☐ YES ☐ NO relation: _____

Other _____

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SOCIAL HISTORY Gender at birth: FEMALE / MALE Identify as: FEMALE / MALE / OTHER:_____

Relationship status: Married / Single / Divorced / Separated / Widowed / Domestic Partner / Other

Spouse / Partner's Name: _____

Your Occupation: _____ Place of Employment: _____

Type of diet: Regular / Vegetarian / Vegan / Gluten Free / Other: _____

Exercise level: None / Occasional / Moderate / Heavy

Smoking Status: Never / Former / Current Smoker Do you use other forms of tobacco or nicotine? ☐ YES ☐ NO

Alcohol consumption: None / Occasional / Moderate / Heavy **Caffeine consumption**: None / Occasional / Moderate / Heavy

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SURGICAL HISTORY

List surgeries and/or biopsies (Including date, type, hospital, and surgeon)

_____ _____
_____ _____
_____ _____
_____ _____

PAST MEDICAL HISTORY

Attention Deficit Disorder (ADD / ADHD) □ YES □ NO

Cancer – Breast □ YES □ NO
Cancer – Cervical □ YES □ NO

Cancer – Colon □ YES □ NO
Cancer – Endometrial / Uterine □ YES □ NO

Cancer – Lung □ YES □ NO

Cancer – Skin □ YES □ NO

Cancer – Vaginal □ YES □ NO
Cancer – Vulvar □ YES □ NO

Cardiology – Heart Arrhythmia □ YES □ NO

Cardiology – Heart Disease □ YES □ NO
Cardiology – High Blood Pressure □ YES □ NO

Cardiology – High Cholesterol □ YES □ NO
Dermatology – Acne □ YES □ NO
Dermatology – Eczema / Psoriasis □ YES □ NO

ENT – Hearing Loss □ YES □ NO

ENT – Seasonal Allergies / Allergic Rhinitis □ YES □ NO
Endocrinology – Diabetes □ YES □ NO
Endocrinology – Glucose Intolerance / Insulin Resistance □ YES □ NO
Endocrinology – History of Gestational Diabetes □ YES □ NO
Endocrinology – Hyperthyroidism □ YES □ NO
Endocrinology – Hypothyroidism □ YES □ NO
Endocrinology – Osteopenia □ YES □ NO
Endocrinology – Prolactinoma □ YES □ NO
Endocrinology – Thyroid Problems □ YES □ NO
Endocrinology – Vitamin Deficiency □ YES □ NO
Eyes – Glaucoma □ YES □ NO
Eyes – Vision Loss / Macular Degeneration □ YES □ NO
GI – Colon Polyps □ YES □ NO
GI – Crohn's / Ulcerative Colitis □ YES □ NO
GI – Gallbladder Disease □ YES □ NO
GI – Hemorrhoids □ YES □ NO
GI – Irritable Bowel Syndrome □ YES □ NO
GI – Liver Disease / Hepatitis □ YES □ NO
GI – Reflux / Ulcers □ YES □ NO

GYN – Dysplasia □ YES □ NO
GYN – Endometriosis □ YES □ NO
GYN – Fibroids □ YES □ NO
GYN – Infertility □ YES □ NO
GYN – PCOS □ YES □ NO
Hematology – Anemia □ YES □ NO
Hematology – Bleeding Disorder □ YES □ NO
Hematology – Blood Clotting Disorder / Factor V Leiden □ YES □ NO
Hematology – Blood Transfusion □ YES □ NO
Hematology – DVT / Pulmonary Embolism □ YES □ NO
Hematology – Other □ YES □ NO
ID – Tuberculosis / Positive PPD □ YES □ NO
ID – Chicken Pox / Shingles □ YES □ NO
ID – HIV □ YES □ NO
ID – Herpes □ YES □ NO
ID – MRSA □ YES □ NO
Nephrology – Renal Disease □ YES □ NO
Neurology – Dementia □ YES □ NO
Neurology – Headaches / Migraines □ YES □ NO
Neurology – Multiple Sclerosis □ YES □ NO
Neurology – Seizures / Epilepsy □ YES □ NO
Neurology – Stroke / TIA □ YES □ NO
Ortho – Arthritis □ YES □ NO
Ortho – Chronic Back Pain □ YES □ NO
Ortho – Fractures □ YES □ NO
Psych – ADD □ YES □ NO
Psych – Anxiety Disorder □ YES □ NO
Psych – Bipolar Disease □ YES □ NO
Psych – Depression □ YES □ NO
Psych – Eating Disorder □ YES □ NO
Psych – PMS / PMDD □ YES □ NO
Pulmonary – Asthma □ YES □ NO
Pulmonary – COPD / Emphysema □ YES □ NO
Pulmonary – Seasonal Allergies □ YES □ NO
Pulmonary – Sleep Apnea □ YES □ NO
Rheumatology – Arthritis □ YES □ NO
Rheumatology – Autoimmune Disease □ YES □ NO
Rheumatology – Fibromyalgia / Chronic Pain □ YES □ NO
Rheumatology – Restless Leg Syndrome □ YES □ NO
Urology – Hematuria (Blood in urine) □ YES □ NO
Urology –Interstitial Cystitis □ YES □ NO
Urology –Recurrent Urinary Tract Infections □ YES □ NO
Urology –Stones □ YES □ NO
Urology – Urinary Incontinence □ YES □ NO
Vascular – Aneurysm □ YES □ NO
Weight Management / Obesity □ YES □ NO

OTHER: _____ _____
_____ _____
_____ _____
_____ _____