ALPENGLOW WOMEN'S HEALTH

Patient Information

Name ______________________ D.O.B ____________

Pronouns ○He/Him ○She/Her ○They/Them ○__________

Gender Identity ○Male ○Female ○FTM ○MTF ○Other

Current Care Team

Provider __________________ Specialty __________________

Provider __________________ Specialty __________________

Today's Date ______________________________________

Current Medications *(including over the counter):*

Name of Drug	Dose (include strength and number of pills per day)	Prescribed by

Preferred Pharmacy

Gynecologic History

Date of last Pap smear ____________________ Abnormal Pap smear ____________________ Date of LMP __________________

Flow _______________ Duration of flow (days) __________ Frequency of cycle (Q days) __________ Age at 1st period ________

If post-menopausal, age at menopause _______ HPV vaccine _______ Sexually active ___________ STIs/STDs ____________

Age at first child _______ Current birth control method __________________ Desired birth control method ___________________

History of sterilization/partner vasectomy _______ Date of last colonoscopy ___________ Date of last mammogram ___________

Most recent bone density ______________ Post menopausal bleeding ___________ Hormone replacement therapy ___________

Obstetric History

Total	Full Term	Premature	Terminated	Miscarriage	Ectopic	Multiple births living
_______	_______	_______	_______	_______	_______	_______

Delivery Date	Delivery Type (Vaginal, Cesarean, Miscarriage, Termination)	Gestational weeks of Delivery	Sex	Name	Weight	Delivery Location	Complications

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Family History	*Circle One*	*Age of Death*	*Health issues / Cause of death if deceased*
Father	Alive / Deceased		
Mother	Alive / Deceased		
Paternal Grandfather	Alive / Deceased		
Paternal Grandmother	Alive / Deceased		
Maternal Grandfather	Alive / Deceased		
Maternal Grandmother	Alive / Deceased		

How many siblings? _______ Brothers _______ Sisters _______ Sons _______ Daughters

Social History

Education and Occupation

Are you currently employed? Y / N

Occupation ______________________________

What is the highest grade or level of school you have completed or the highest degree you have received?

____

Marriage and Sexuality

What is your relationship status? ______________________________

Do you use protection against STDs? Y / N

Substance Use

Do you or have you ever smoked tobacco? Y / N

Years smoked ____________ Packs per day ____________

Do you or have you ever used any other forms of tobacco or nicotine? Y / N

Type ____________

Do you use any illicit or recreational drugs? Y / N

Type ____________

What is your level of alcohol consumption? ____________

Surgical History *(include date of surgery)*	Hospitalizations *(include dates and reason)*

Medical History *(Do you have now or have you ever had):*

- O Diabetes (type) ____________
- O High Blood Pressure
- O High Cholesterol
- O Hypothyroidism
- O Hyperthyroidism
- O Cancer (type) ____________
- O Leukemia
- O Heart Murmur
- O Heart problems
- O Pneumonia
- O Stroke
- O Asthma
- O Epilepsy
- O Glaucoma
- O Kidney Disease
- O Kidney Stones
- O Crohn's Disease
- O Colitis
- O Anemia
- O Jaundice
- O Hepatitis
- O HIV/AIDS
- O Tuberculosis
- O Stomach Ulcer
- O Gallstones
- O Migraines
- O Anxiety
- O Depression
- O Skin Disorders
- O Eating Disorder
- O Rheumatic Fever
- O Other: ____________

Allergies

Type of Allergen *(i.e. penicillin or nickel)*	Reaction *(i.e. anaphylaxis, swelling, rash, other*