

Bothell Women's Health
Health Inventory

Name: _____ Age: _____ DOB: _____ Occupation: _____

Preferred Pharmacy Name: _____

Pharmacy Location and Phone Number: _____

Living Situation: Alone Friend(s) Partner Spouse Parents

Names and Ages of those living with you: _____

Current Health Status: Excellent Good Fair Poor

Allergies (to medications): _____

Current Medications and Dosages:

Supplements:

Past Medical History (list any major medical problems and/or diagnoses with dates if possible)

Hospitalizations/Operations:

List of Practitioners you are currently seeing and what you are seeing them for:

Name	Location	Reason
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Obstetric History:

Are you planning a pregnancy in the next 6 months? YES / NO

of Pregnancies: _____ # of Births: _____ # of Miscarriages _____ Any significant complications w/ pregnancy or delivery? _____

Gynecologic History:

Are you sexually active? YES / NO Any pain with intercourse? YES / NO Describe: _____

Any sexual concerns to discuss? _____

Current birth control method: _____ How long? _____

Problems with it? _____

Any past history of Sexually Transmitted Disease? _____

Any unusual pelvic pain, pressure or fullness? _____ When? _____ Describe: _____

Any unusual vaginal discharge or itching? _____ When? _____ Describe: _____

Are you currently having periods? YES / NO

If YES:

Date of last period? _____

Are they regular? YES / NO Average # Days of flow: _____ Length of cycle: _____

Amount of flow: Heavy Moderate Light Severity of Cramps: Light Moderate Severe

Premenstrual Symptoms: _____

Any bleeding between periods? YES / NO When? _____

Do you have concerns about your periods? _____

If NO:

Menopause, at age _____ Natural / Hysterectomy Date & Reason: _____ Ovaries intact? YES / NO

Are you currently taking hormones? Type & Dose? _____

Any bothersome (peri) menopausal symptoms? _____

Pap Smears: Date of last Pap: _____ Clinic where Pap was done: _____

Previous abnormal results? YES / NO **If YES:** When? _____ Test Results/Treatments: _____

Breasts: Date of last Mammogram: _____ Facility: _____ Results? _____

Any previous problems/concerns with Breasts? _____

Have you had a DEXA scan? YES / NO Date & Results: _____ normal / osteopenia / osteoporosis

Have you had a Colonoscopy YES / NO Date & Results: _____

Habits:

Dietary Restrictions: _____

Routine Physical Activity: Type of exercise: _____

Length of workout: _____ How often? _____

Caffeine use (how much): _____ Tobacco use: (how much): _____ History? _____

Alcohol use: (how much): _____ History? _____

Current or previous Drug use (what and when): _____

Current Stresses (family, work, self, etc): _____

Family History:

<u>Yes</u>	<u>No</u>	<u>Who</u>	<u>Yes</u>	<u>No</u>	<u>Who</u>
___	___	Breast Cancer _____	___	___	Skin Cancer _____
___	___	Ovarian Cancer _____	___	___	Diabetes _____
___	___	Colon Cancer _____	___	___	Heart Disease _____
___	___	Hypertension _____	___	___	Osteoporosis _____
___	___	Thyroid disorder _____	___	___	Blood Clots _____
___	___	Alcoholism _____	___	___	Depression _____

Review of Systems: (Check any symptom of **current** concern.)

General: Fever or chills Hot flashes Unusual Hair growth Skin eruptions Wt. Change

Abdomen: Bloating Heartburn Nausea/vomiting Diarrhea Constipation

Hemorrhoids Cramps Change in bowel habits Gas/indigestion Bloody stool

Head: Headaches Dizziness Visual Changes Hearing Changes Sinus trouble

Chest: Chest pain Shortness of breath Palpitations Asthma/Wheezing Cough

Heart murmur Mitral Valve Prolapse

Breasts: Lumps Tenderness Nipple Discharge Bleeding

Bladder: Frequent urination Painful urination Leakage of urine Blood in urine

Psychiatric: Depression Anxiety Mood instability

Muscle/Skeletal Bone & joint pain

Other: _____