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): ____

Personnel Health GOALS:____

Family History or Personal History:

	ME	Family: Who		ME	Family: Who
Breast Cancer	☐	_____________	Skin Cancer	☐	_________________
Ovarian Cancer	☐	_____________	Alcoholism	☐	_________________
Colon Cancer	☐	_____________	Thyroid disorder	☐	_________________
Hypertension	☐	_____________	Osteoporosis	☐	_________________
Blood Clots	☐	_____________	Depression	☐	_________________
Heart Disease	☐	_____________	Hypertension	☐	_________________
High Cholesterol	☐	_____________	Early Menopause	☐	_________________
Metabolic Syndrome/PCOS	☐	_____________	Kidney Disease	☐	_________________
Chronic Inflammatory Diseases (RA, Psoriasis, Hepatitis, Other Cancers)				☐	_________________

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: ____