Bothell Women's Health

Health Inventory

Name: _____ Age:_____ DOB:_____Occupation: _____

Preferred Pharmacy: _____Location & 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

Are you establishing with us as PRIMARY CARE: YES NO

If NO, who is your Primary Care Provider? _____

Name / Clinic & Location / Phone & Fax #

Current Medications and Dosages (Please attach additional page if needed):

Supplements/Vitamins:

ALLERGIES (to medications): _____

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: _____