

**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**

**Who is your current or most recent Primary Care Provider?**

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Provider Name	/	Clinic & Location	/	Phone & Fax #
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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)

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**Past Hospitalizations/Operations:**

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**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): \_\_\_\_\_

Personal Health GOALS: \_\_\_\_\_

**Family History or Personal History:**

	<u>ME</u>	<u>Family: Who?</u>		<u>ME</u>	<u>Family: Who?</u>
Breast Cancer	<input type="checkbox"/>	_____	Skin Cancer	<input type="checkbox"/>	_____
Ovarian Cancer	<input type="checkbox"/>	_____	Alcoholism	<input type="checkbox"/>	_____
Colon Cancer	<input type="checkbox"/>	_____	Thyroid disorder	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	_____	Osteoporosis	<input type="checkbox"/>	_____
Blood Clots	<input type="checkbox"/>	_____	Depression	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	_____	Anxiety	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	_____	Early Menopause	<input type="checkbox"/>	_____
Metabolic Syndrome/PCOS	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	_____
Chronic Inflammatory Diseases (RA, Psoriasis, Hepatitis, Other Cancers)	<input type="checkbox"/>	_____		<input type="checkbox"/>	_____

**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:** \_\_\_\_\_