INNOVATIVE HEALTH

General Information: FEMALE Date: ________________

Name:____ Age: _______ Who referred you to us? ____________________________

Who is your primary care provider: ________________________________ Who is your gynecologist? ____________________________

What pharmacy do you use: ____ Location ______________________________

What is the primary reason for your visit? ____

Do you require antibiotics before dental procedures? ☐ Yes ☐ No

Have you had a blood transfusion? ☐ Yes, Date: __________ ☐ No

Past Medical History:

Please check any problems below that you have had, or are currently experiencing:

☐ Acid Reflux/Heartburn	☐ Emphysema	☐ Kidney Disease	☐ Seizures
☐ Alcoholism	☐ Exposure to HIV/AIDS	☐ Kidney Stones	☐ Sleep Apnea
☐ Anemia	☐ Fibromyalgia	☐ Lung Disease (COPD)	☐ Stroke
☐ Anxiety Disorder	☐ Glaucoma	☐ Lupus Erythematosus	☐ Thyroid Disease
☐ Arthritis	☐ Heart failure	☐ Migraines	☐ Tuberculosis
☐ Colitis	☐ Hepatitis B	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Deep Vein Thrombosis	☐ Hepatitis C	☐ Pancreatitis	☐ Unspec. Chronic Fatigue
☐ Depression	☐ High Blood Pressure	☐ Pneumonia	☐ Breast Cancer
☐ Diabetes	☐ High Cholesterol	☐ Pulmonary Embolus	☐ Ovarian Cancer
☐ Diverticulitis	☐ HIV	☐ Rash	☐ Endometrial Cancer
☐ Eating Disorder	☐ Interstitial Cystitis	☐ Raynaud's	☐ Uterine Sarcoma
☐ Eczema	☐ Irritable Bowel Syndrome	☐ Seasonal Allergies	☐ Other Cancer

Date of Flu Vaccine:_______ Date of Pnuemonia Vaccine:___________ Other:___________________________

Past Surgical History:

Please check all previous surgeries you have had:

☐ Abdominal Hysterectomy	☐ Colonoscopy Date: ________________	☐ Lung Surgery	☐ Thyroid Surgery
☐ Angioplasty	☐ Cystocele Repair	☐ Lumpectomy	☐ Tonsillectomy
☐ Appendectomy	☐ Gall Bladder Surgery	☐ Kidney Stones	☐ Tummy Tuck
☐ Back Surgery	☐ Heart By-pass Surgery	☐ Paravaginal Repair	☐ Vaginal Hysterectomy
☐ Bladder Suspension	☐ Hernia Surgery	☐ Rectocele Repair	☐ Other:
☐ Breast Augmentation	☐ Hip Replacement	☐ Removal of Ovaries	____________________
☐ Cancer Removal Surgery Type: ________________ Date: ________________	☐ Knee Replacement	☐ Sling Procedure Date: ________________	____________________

Present Medications:

Please list or attach list of all medications, supplements, over the counter meds and the dosage amounts:

____

____

____

Allergies:

Please list all allergies you have:

Medication Allergies:	Food Allergies:	Environmental Allergies:
____________	____________	____________
____________	____________	____________
____________	____________	____________

Family Medical History:

Please check any conditions that are prevalent in your immediate family:

☐ Asthma	☐ Diabetes	☐ Heart Attack	☐ Mental Illness
☐ Breast Cancer	☐ Gynecologic Cancer	☐ Interstitial Cystitis	☐ Stroke
☐ Colon Cancer			

Reproductive History:

Approximate date of last Menstrual Period: ____________

Do you have any abnormal bleeding?	☐ Yes	☐ No
Do you have pain with menstrual periods?	☐ Yes	☐ No
Are you sexually active?	☐ Yes	☐ No
Do you take birth control pills?	☐ Yes	☐ No

Total no. of pregnancies: _____ No. of vaginal deliveries: _____ No. of C-sections: _____ No. of live births: _____

Did you experience any of these problems with vaginal deliveries?

☐ Forceps ☐ Breech ☐ Tears ☐ Episiotomies

Date of last pap smear: ______ ☐ Normal ☐ Abnormal Details: ____________

Date of last mammogram: ____________ Where was it performed: ____________

☐ Normal ☐ Abnormal Details: ____________

Date of last bone density: ____________ Where was it performed: ____________

☐ Normal ☐ Abnormal Details: ____________

Social History

Please check all that apply to you:

Alcohol	Cigarettes	Illicit Drugs
☐ Currently Use	☐ Currently Use	☐ Currently Use
☐ Never Use	☐ Never Use	☐ Never Use
☐ Previously Used	☐ Previously Used	☐ Previously Used

Martial Status:

☐ Married ☐ Single ☐ Widowed ☐ Divorced