



MAA

Women's Health

ESTABLISHED PATIENT

Patient Name: _____ Date of Birth: _____

Current in Insurance: _____

Current Pharmacy: _____

Current Pharmacy Address: _____

Change in Home address? _____

Problem/ Concerns you want to discuss today: _____

Changes:

Any changes in Medical History?

Any changes in Family History?

Current Medications

Any changes in Surgical History?

Any changes in Social History?

Allergies

GYN:

Birth control? _____

Normal menstrual periods? _____

Last menstrual period: _____

BP: _____ / _____ PR: _____ Pulse Ox: _____ Wt: _____ Ht: _____ Temp: _____

Do you have problems with

Difficulty sleeping	☐	Headache	☐	Vomiting/ Nausea	☐
Sudden wgt gain/loss	☐	mouth lesions	☐	Digestion and bowels	☐
Decreased energy	☐	Difficulty swallowing	☐	Loss of sensation	☐
Decreased appetite	☐	Change in voice	☐	Breast lumps/ pain	☐
Problems with memory	☐	Cough	☐	Vaginal discharge	☐
Blood in urine or stool	☐	Difficulty breathing	☐	Abnormal menstruation	☐
Lumps in body	☐	Chest pain	☐	Pain in abdomen	☐
Skin changes	☐	Irregular heart rate	☐	Pelvic pain	☐
Nose/throat/voice	☐	Swelling/ fluid in legs	☐	Lesions vulvar area	☐
Eyes or vision	☐	Joint swelling/ pain	☐	Problems with urination	☐
Hearing prob/ ears	☐	Difficulty walking	☐	Problems with passing stools	☐

Patient Signature: _____

Date: _____