

Although some of the information requested below may not seem pertinent, it helps us provide you with the best care. Please fill out ALL of the following questions completely.

1) DATE _____ NAME _____ DOB _____ AGE _____

2) Preferred PHARMACY NAME: _____ PHARMACY ADDRESS: _____

3) Changes in Marital Status since your last visit? _____

4) WPIH Physician: Swenson Wehs Reich Yium Oliver Nash Ikbal Kung Summers

5) REASON FOR VISIT (please explain your symptoms and how long they have been occurring) _____

6) Please list current MEDICATIONS: _____ Do you smoke cigarettes? Yes No

7) Please list any significant ALLERGIES (i.e. LATEX, eggs, shellfish, etc.) _____

8) When was the FIRST day of your LAST MENSTRUAL PERIOD? (If applicable) _____

How many days do you have bleeding? (i.e. 4 days) _____ How OFTEN do your periods occur? (i.e. every 28days) _____

9) What is your CURRENT BIRTH CONTROL METHOD? (Please choose one):

Nothing... withdrawal... condoms... pills/ring/patch... IUD... tubal... vasectomy... menopause... hysterectomy... OTHER _____

If applicable, please list brand name of birth control pills/ring/patch/IUD: _____

If you have any concerns about this birth control method, please explain: _____

10) The American College of Obstetrics and Gynecology (ACOG) recommends the following screenings during your annual exam:

- HIV screening for all women ages 19-64
- HIV screening for sexually active teenagers under the age of 19
- HIV screening for women older than 64 who have had multiple partners in recent years
- Annual Chlamydia screening of all sexually active women age 25 and younger
- HPV (human papilloma virus) screening, in addition to an annual pap smear, for women over the age of 30

I would like to be screened for the following sexually transmitted diseases today: (please circle) **HPV Chlamydia Gonorrhea Genital herpes HIV Syphilis Hepatitis B No testing today** **Note: We cannot guarantee insurance coverage for any tests**

11) Please list any CHANGES to your Medical/Surgical/Family history since you were last seen in our offices: _____

12) Please circle any of the symptoms below that you are having TODAY:

Constitutional:	Circle One:	Genitourinary (continued)	Circle One:
Frequent Fatigue	Current Past N/A	Frequent Urine leakage	Current Past N/A
Excess weight gain	Current Past N/A	Pain with intercourse	Current Past N/A
Excess weight loss	Current Past N/A	Genital sores	Current Past N/A
Eyes, Ears, Nose, Mouth:	Circle One:	Irregular periods	Current Past N/A
Frequent or severe headaches	Current Past N/A	Painful periods	Current Past N/A
Frequent lightheadedness	Current Past N/A	Heavy periods	Current Past N/A
Breasts:	Circle One:	No periods	Current Past N/A
Lumps	Current Past N/A	Possible pregnancy?	Current Past N/A
Tenderness/ Pain	Current Past N/A	Abnormal vaginal discharge	Current Past N/A
Swelling	Current Past N/A	Significant PMS	Current Past N/A
Nipple discharge	Current Past N/A	Integument (skin):	Circle One:
Cardiovascular:	Circle One:	New skin lesions	Current Past N/A
Chest pain	Current Past N/A	Changes to skin lesions or moles	Current Past N/A
Dizziness/Fainting	Current Past N/A	Musculoskeletal:	Circle One:
Swollen/Painful varicose veins	Current Past N/A	Joint pain	Current Past N/A
Calf pain	Current Past N/A	Joint swelling	Current Past N/A
Respiratory:	Circle One:	Recent back pain	Current Past N/A
Frequent shortness of breath	Current Past N/A	Endocrine:	Circle One:
Frequent Hoarseness	Current Past N/A	Excess bodily hair growth	Current Past N/A
Gastrointestinal:	Circle One:	Excess hair loss	Current Past N/A
Nausea/ Vomiting	Current Past N/A	Cold intolerance	Current Past N/A
Frequent Diarrhea	Current Past N/A	Heat intolerance	Current Past N/A
Frequent Constipation	Current Past N/A	Acne	Current Past N/A
Frequent Heartburn/ reflux	Current Past N/A	Thyroid abnormalities/ treatment?	Current Past N/A
Abdominal Pain	Current Past N/A	Psychiatric:	Circle One:
Blood in stool	Current Past N/A	Frequent Anxiety	Current Past N/A
Hemorrhoids	Current Past N/A	Frequent Depression	Current Past N/A
Genitourinary:	Circle One:	Suicidal thoughts	Current Past N/A
Urgency/ frequency	Current Past N/A	Past/Current psychiatric treatment	Current Past N/A
Pain with urination	Current Past N/A	Hematologic/Lymphatic:	Circle One:
Blood in urine	Current Past N/A	Easy bleeding	Current Past N/A
		Easy bruising	Current Past N/A

Patient Signature _____ Date: _____

FOR STAFF ONLY BELOW THIS POINT:

** DO NOT SCAN THIS SIDE **

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Account # _____

Visit Care Provider: KS DW SR VY DO FN NI AK JS NL SS

Weight _____ Height _____ BP _____ Temp _____ UPT: Positive Negative

C.10 Results: Glucose _____ Bili _____ Ketones _____ Sp.Gravity _____ Blood _____ pH _____ Protein _____
Urobili _____ Nitrite _____ Leuk _____

Pt desires: STD Testing.....Lipids.....Other _____

LABS ORDERED: _____

DIAGNOSIS CODES: _____

PROCEDURE CODES: _____