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PROGRESSIVE WOMENS HEALTH, PLLC
ASIA MOHSIN, MD

FEMALE MEDICAL HISTORY

Today's Date: _____
Last Name: _____ First Name: _____ Date of Birth: _____
Pharmacy Name/Location: _____ Pharmacy Phone #: _____
Allergies to Medications, Foods, or Substances (e.g. Latex): _____
Do you currently have any of the following advanced directives? □DNR □Living Will □Organ Donor □Power of Attorney
Height: _____ Previous Weight: _____

Reason for this visit:

Medications, OTC, Vitamins:

PAST MEDICAL HISTORY

FAMILY HISTORY

Please complete for your first visit at our office. This form is confidential. Please check "Yes" or "No" if you currently or have you ever had any of the following conditions?

Yes	No		Yes	No	Which Family Member?
□	□	Depression or any psychiatric illness	□	□	_____
□	□	Headaches/migraines	□	□	_____
□	□	Blood clots (i.e. DVT, PE)	□	□	_____
□	□	Liver disease	□	□	_____
□	□	Diabetes, □Type I □Type II	□	□	_____
□	□	Cancer – Type _____	□	□	_____
□	□	High blood pressure	□	□	_____
□	□	Stroke	□	□	_____
□	□	Ulcers	□	□	_____
□	□	Persistent Urinary Tract Infections	□	□	_____
□	□	Arthritis or joint problems	□	□	_____
□	□	Osteoporosis	□	□	_____
□	□	Lung disease (i.e. asthma, COPD)	□	□	_____
□	□	Heart disease – Type _____	□	□	_____
□	□	Thyroid Disease	□	□	_____
□	□	High cholesterol or lipids	□	□	_____
□	□	Blood transfusion	□	□	_____
□	□	Tuberculosis or other infections	□	□	_____
□	□	Seizure disorder	□	□	_____
□	□	Uterine Fibroids/Ovarian Cysts	□	□	_____
□	□	Abnormal Vaginal Bleeding	□	□	_____
□	□	Endometriosis	□	□	_____
□	□	Fibrocystic breasts	□	□	_____
□	□	Other – Please list: _____	□	□	_____

Last Name: _____ First Name: _____ Date of Birth: _____

MENSTRUAL HISTORY

GYNECOLOGY HISTORY

Please answer the following questions:

When was your last menstrual period? _____
At what age, did you get your first period? _____
How often do you get your period? _____
How long does your period last? _____
Is your menstrual flow heavy? _____

Have you had any of the following exams?
Please state if the test result was normal/abnormal?

Yes	No		Dates:
□	□	PAP Smear	_____
□	□	Mammography	_____
□	□	Pelvic ultrasound	_____
□	□	Bone density scans	_____

OBSTERTRICS HISTORY

Have you had any of the following?

Yes	No		How many?
□	□	Pregnancies	_____
□	□	Miscarriages	_____
□	□	Living Children	_____

HOSPITALIZATIONS

Have you ever been admitted to the hospital and for what?

_____
_____
_____
_____
_____

SURGICAL HISTORY

Have you had any of the following procedures/exams?

Yes	No	
□	□	Hysterectomy (uterus)
□	□	Oophorectomy (ovaries)
□	□	Tubal ligation
□	□	Colonoscopy
□	□	Other – Please list: _____

SOCIAL HISTORY

Do you do/use any of the following?

Yes	No		How much/often?
□	□	Alcohol	_____
□	□	Tobacco	_____
□	□	Caffeine	_____
□	□	Drugs	_____
□	□	Exercise	_____

QUESTIONAIRE

Yes	No	
□	□	Do you plan to have more children?
□	□	Are you currently breastfeeding?
□	□	Are you currently pregnant?
□	□	Are you currently sexually active?
□	□	Have you ever-used contraceptives? If yes, list medications, dose, directions, and duration of treatment. _____ Did you have any problems? If yes, please explain. _____
□	□	Have you ever-used hormone replacement therapy? If yes, list medications, dose, directions, and duration of treatment. _____ Did you have any problems? If yes, please explain. _____
□	□	Do you currently follow a special diet? If yes, please explain. _____
□	□	Do you have urinary or stool incontinence?
□	□	Do you have any sexual complaints? If yes, please explain. _____
□	□	Does your spouse have any sexual complaints (i.e. erectile dysfunction, low testosterone)? If yes, please explain. _____

Patient's Signature: _____ Date: _____