Women's Health Associates, Inc.
PH: 781-237-0080

Green Building Suite 760
2000 Washington Street
Newton, MA 02462

MEDICAL INFORMATION

Name: ______________________________ Date: ________________

Marital Status: __________ Occupation: ____________________________

DOB: ___-____-____ Referred by: ____________________________

Pharmacy: _________________ Street/Town: ____________________________

MEDICAL HISTORY (including surgeries, biopsies, hospitalizations, and procedures)

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MEDICATIONS, VITAMINS & SUPPLEMENTS

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ALLERGIES
(Drugs/environment)

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GYNECOLOGICAL HISTORY

Age Menses first began: _____ Total # of Pregnancies: ____ # of Children: _____

Date of last Pap smear: ______________________ Results: __________

Date of last Mammogram: ______________________ Results: __________

History of Sexually Transmitted Diseases? ____________________________

TURN PAGE OVER

SMOKING

NONE: ____________

Current: ___________

ALCOHOL USE

Frequency_______________

Type: ___________________

CAFFEINE INTAKE

Beverage: ________________

Cups per day: _____________

EXERCISE:
Type: ________________________________ Frequency: ______________________________________

SEAT BELT USE: ______________________________

DATE OF LAST:

EYE EXAM: _____________________ DENTAL EXAM: ___________________

TETANUS BOOSTER: _____________ HEPATITIS B VACCINE: ____________

FAMILY HISTORY (heart disease, diabetes, high blood pressure, osteoporosis, cancer, including breast, ovarian, colon prostate)

MOTHER (age :_____) ____

Father (age: ______) ____

Siblings (# _______) ____

Maternal Grandmother ____

Maternal Grandfather ____

Paternal Grandmother ____

Paternal Grandfather ____

Other Relatives ____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Have you ever been in a relationship where you suffered from physical and/or verbal abuse past or present?

____

Have you ever suffered from depression or anxiety? ____________________
If yes, were you treated? ____

Have you ever suffered from any type of eating disorder? ________________________

If yes, did you undergo treatment? ____