Wesley Women's Care
3243 E. Murdock, Medical Arts Tower G-Level
Wichita, KS 67208

Name:_____Birthdate:_____

Reason for Visit:_____Primary Care Physician:_____

Pharmacy #1:_____ City:_____ Location:_____
Pharmacy #2:_____ City :_____ Location:_____

Please include all over the counter medications and prescription medications.

Medication	Dose/Strength	# of pills/amt	Times/ day

Medication allergies and **reactions**: _____

Medical History

Please check if you have or have ever been diagnosed with any of the following conditions.

__Anemia
__Arthritis
__Asthma
__Blood Clot
__Blood Transfusion
__Chronic Urinary Infection
__Crohn's Disease
__Diabetes (type_____)
__Diverticulitis
__Elevated Cholesterol
__Irritable Bowel Syndrome
__Kidney Stones
__Lupus
__Migraines
__Epilepsy
__Fibromyalgia
__Heart Disease
    __Angina
    __Congestive Heart Failure
    __Coronary artery disease
    __Mitral valve prolapse
__Heartburn/Reflux
__Hepatitis (type_____)
__High Blood Pressure
__Stroke
    __Thyroid Disorder
    __Hyperthyroid
    __Goiter

__Psychiatric Disorder
- __Bipolar Disorder
- __Depression
- __Obsessive/Compulsive
- __Schizophrenia

__Hypothyroid
- __Graves Disease

__Other
_____
_____

GYN PROBLEMS

__Abnormal Pap Smears
__Bartholin Cyst
__Breast Cancer
__Breast Lump
__Cervical Cancer
__Cervical Dysplasia
__Chronic Vaginal Infections
__Chronic Pelvic Pain
__Endometrial Hyperplasia
__Endometriosis
__Fibrocystic Breast
__Habitual Aborter (>3 Miscarriages)
__Infertility
__Ovarian Cancer
__Ovarian Cyst
__Heavy Bleeding
__Irregular Periods
__Lichen Sclerosis
__Pelvic Inflammatory Disease
__Prolapse
__Sexually Transmitted Disease
- __Chlamydia
- __Genital Warts
- __Gonorrhea
- __Herpes
- __Trichomonas

__Urinary Incontinence
__Uterine Cancer
__Uterine Fibroids
__Other _____

Date Last Menstrual Period began: _____ Age when you started having periods:_____
Amt of menstrual flow: __Light __Moderate __Heavy
How many days do you flow? _____, Every_____days
Date of last Pap Smear:_____, Normal or Abnormal?
Are you currently sexually active? __Yes __No
What type of birth control do you currently use? _____

Number of pregnancies _____ Full term deliveries _____ Pre term deliveries _____
Miscarriages/Abortions _____ Living Children_____ **Are you currently pregnant?**_____

OBSTETRICAL HISTORY

Please fill out for each pregnancy even if it was a miscarriage or abortion. If you have had a tubal ligation, hysterectomy, or are over the age of 50, only date and type of delivery are necessary.

	TYPE OF DELIVERY	DATE OF DELIVERY	NAME OF BABY	GEST. AGE	WT.	SEX M/F	HOSPTIAL	DOCTOR	COMPLICATION
1	Miscarriage Vaginal Delivery C Section Abortion			TERM PRETERM					
2	Miscarriage Vaginal Delivery C Section Abortion			TERM PRETERM					
3	Miscarriage Vaginal Delivery C Section Abortion			TERM PRETERM					
4	Miscarriage Vaginal Delivery C Section Abortion			TERM PRETERM					
5	Miscarriage Vaginal Delivery C Section Abortion			TERM PRETERM					
6	Miscarriage Vaginal Delivery C Section Abortion			TERM PRETERM					

SURGICAL HISTORY

Have you ever had any of the following surgeries and if so when?

Procedure	Yes	No	Year
Arthroscopy			
Appendectomy/Appendix			
Cataracts			
Cardiac Surgery			
Cystoscopy			
Gallbladder Removed			
Hip Replacement (Right or Left)			
Knee Replacement (Right or Left)			
Sinus Surgery			
Tonsillectomy			
Tonsillectomy/Adenoids			
Tubes in Ears			
Wisdom Teeth Extraction			

HOSPITALIZATIONS

Have you ever been admitted, (longer than 24 hours) to the hospital for any illnesses or injuries?

Year	Reason	Hospital

GYN HISTORY

Procedure	Yes	No	Year
Breast Augmentation			
Breast Biopsy			
Breast Reduction			
Cesarean Section			
Cervical Proceures			
-Cone Biopsy			
-Cryo			
-Laser			
-LEEP			
-Colposcopy			
D&C			
Endometrial Ablation			
Hysteroscopy			
Hysterectomy (Abdominal or Vaginal)			
Laparoscopy			
Mastectomy (Right/Left/Bilateral)			
Ovaries Removed (Right/Left/Bilateral)			
Tubal Ligation			

SOCIAL HISTORY

Tobacco Use: __No __Yes __Former Frequency; _____ Year Quit: _____

Alcohol: __No __Yes __Former Frequency: _____ Year Quit: _____

Illicit Drug Use: __No __Yes __Former
Type: _____ # Years: _____ Year Quit: _____

Caffeine: ___ cups per day
Seat belt use: __yes __no
History of domestic abuse: __Sexual __Physical __Emotional

History of depression: __Past __Current

Diet: __Diabetic __Healthy __High Fat __Low Fat __Low Sodium __Junk Food

Exercise: __2-3x/week __3-4x/week __Daily __Never __Occasional __Rarely

Highest Grade Level Completed_____

Occupation: _____ __Unemployed __Disabled

Place of Employment: _____

Marital Status: __Married __Divorced __Legally Separated __Single __Widowed
__Engaged __Domestic Partner

Who do you live with: _____

(If pregnant), do you own a cat: __Yes __No

Race: __African-American __Asian __Caucasian __Hispanic __Other:_____

HEALTH MAINTENANCE

Date of Last Pap Smear: _____ **Result:** _____

Date of Last Mammogram: _____ **Result:** _____

Date of Last Colonoscopy: _____ **Result:** _____

Date of Last Bone Density: _____ **Result:** _____

Date of Last Cholesterol Test: _____ **Result:** _____

Chicken Pox Status: __I have had chicken pox __I have had the chicken pox vaccine
__I have had the vaccine and chicken pox __I have had neither the vaccine nor chicken pox

Hepatitis B: __I have received the entire Hepatitis B vaccination series
__I have part of the Hepatitis B vaccination series
__I have not received the Hepatitis B vaccination series

Flu Vaccine: __I have received the Flu vaccine this year.
Year of Last Tetanus Vaccine:_____

FAMILY MEDICAL HISTORY

Please check if anyone in your immediate family has been diagnosed or treated for the following:

Adopted__

L = Living **D = Deceased** **U = Unknown**	**Mother**	**Father**	**Sister**	**Brother**	**Daughter**	**Son**	**MGma**	**MGpa**	**PGma**	**PGpa**
Breast Cancer										
Colon Cancer										
Ovarian Cancer										
Diabetes										
Hypertension										
Stroke										
Heart Disease										
Thyroid Disorder										
Osteoporosis										
Epilepsy										
Kidney Problems										
Lung Disease										

REVIEW OF SYMPTOMS

Please complete this form and mark yes for the symptoms that you are experiencing TODAY.

Yes	No	Symptom	Yes	No	Symptom
		Fatigue			Diarrhea
		Wt. Loss			Heartburn
		Fever_____F			Vomiting
		Wt. Gain			Bloody Stools
		Chills			Bloating
		Night Sweats			Cold Intolerance
		Ear Pain L/R/Bilat			Heat Intolerance
		Hearing Loss L/R/Bilat			Hair Loss
		Visual Loss L/R/Bilat			Headache
		Congestion			Numbness
		Runny Nose			Dizziness
		Sore Throat			Anxious
		Short of Breath			Depressed
		Cough			Sleep Disturbance
		Wheezing			Acne
		Chest Pain			Itching
		Palpitations			Rash
		Swelling			Back Pain
		Abdominal Pain			Bone/Joint Pain
		Constipation			Muscle Pain
		Change in Bowels			Easy Bleeding
		Nausea			Pinpoint Bruising
		Easy Bruising			

Use this checklist to find out if you or someone you know is at nutrition risk. Read the statements below. Circle the number in the yes column for those that apply. Total your nutrition score and return this form to the staff.

		YES	Please check if you would like nutrition information on topic
1	I am pregnant or breast feeding.	2	
2	I eat less than 5 servings of fruits and vegetables and less than 3 servings of meat per day.	2	
3	I eat fewer than 2 meals per day.	2	
4	I do not eat 3 or more servings of milk products per day.	2	
5	I drink beer, wine or liquor.	2	
6	If pregnant, I am gaining too much or too little weight.	2	
7	I have an illness or condition that may make my pregnancy high risk.	2	
8	I am pregnant and under 16 years old.	2	
	Total		

Total your nutrition Score. If it's---

0-2 Good! Recheck your nutrition score in 3 months.

3-5 **Moderate Risk.** See what can be done to improve your eating habits and lifestyle. The staff can provide you with nutrition information and or refer you to a registered dietician.

6 or more **You are at high nutritional risk.** It is recommended you see a dietician.