Excellence in Women's Healthcare; Linda Sewell MD

Name_____ Birth Date _____ today's date _____

Please tell us why you are coming for an appointment, and what problems you are having: _____
_____

How many times have you been pregnant _____ How many children do you have _____

How many miscarriages _____ How many abortions _____

Please tell me about your pregnancies:

Year	Vaginal delivery or c-section	Boy or Girl	Name	Weight	Any complications?

When was the first day of your last period? _____ Are your periods regular? _____
Do you have pain with your periods? _____ Do you have pain with sex? _____
Any questions about sex or problems with sex? _____
Do you ever have leakage of urine? _____
When was your last PAP smear? _____ Have you ever had an abnormal PAP? _____ When? _____
Have you ever had any treatment or surgery on your cervix? _____ When? _____
Have you ever had a sexually transmitted disease? _____ What and when? _____
Have you gone through menopause? _____ When? _____
When was your last Mammogram? _____ When was your last bone density scan? _____

List your medical problems

_____
_____
_____

List any surgeries you have had and when

_____
_____
_____

List your medication, include any herbals

_____
_____
_____
_____

List your allergies, and what reaction you have

_____
_____
_____
_____

Do you smoke? _____How much? _____Did you ever smoke? _____ How long? _____

How much alcohol do you drink? _____Do you use any street drugs? _____Did you ever? _____

List any medical problems your family members have had, and who have had them, especially:

Cancers (what type) _____ Diabetes _____

High Blood Pressure _____ Other _____