

SCOTTSDALE CENTER *for* WOMEN'S HEALTH

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MEDICAL HISTORY

Name: _____ Date: _____

Occupation: _____ DOB: _____

Date Last Pap: _____ Date Last Mammogram: _____

Current Medications + Dose <input type="checkbox"/> None	Allergies (to medications) <input type="checkbox"/> None

Obstetrical History: <input type="checkbox"/> None	Gynecological History: <input type="checkbox"/> None
<input type="checkbox"/> Vaginal Delivery	<input type="checkbox"/> Herpes, Gonorrhea, Chlamydia, Genital Warts
<input type="checkbox"/> Cesarean	<input type="checkbox"/> Fibroids of Uterus
<input type="checkbox"/> Terminations	<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Miscarriages	<input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Colposcopy
<input type="checkbox"/> Complications	<input type="checkbox"/> LEEP <input type="checkbox"/> Cryo/Laser

Medical History: <input type="checkbox"/> None	Surgical History: <input type="checkbox"/> None
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hysterectomy <input type="checkbox"/> Cesarean Section
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ovaries Removed <input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tubal Ligation <input type="checkbox"/> D&C
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Laparoscopy
<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Osteopenia	<input type="checkbox"/> Endometrial Ablation
<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Gallbladder
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Appendectomy <input type="checkbox"/> Bladder Suspension
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Breast Augmentation/Reduction
<input type="checkbox"/> Migraines	<input type="checkbox"/> Cosmetic
<input type="checkbox"/> Other	<input type="checkbox"/> Other

Family History:	Social History:
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Smoking
<input type="checkbox"/> Ovarian Cancer	<input type="checkbox"/> Alcohol How Often _____
<input type="checkbox"/> Uterine Cancer	<input type="checkbox"/> Recreational Drugs
<input type="checkbox"/> Colon Cancer	Marital Status - <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Sexual Preference <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both
<input type="checkbox"/> Diabetes <input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Exercise How Often _____
<input type="checkbox"/> Thyroid <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Other
<input type="checkbox"/> Other	

Advance Directives Patient signature: _____

Provider signature: _____