

TODAY'S WOMEN'S HEALTH SPECIALISTS
604 W WARNER ROAD, SUITE E201 • CHANDLER, ARIZONA 85225

HISTORY

Patient Name: _____		DOB: _____		Date: ____/____/____	
<input type="checkbox"/> New Patient	<input type="checkbox"/> Established Patient	<input type="checkbox"/> Consultation	<input type="checkbox"/> Report Sent	____/____/____	
PRIMARY CARE PHYSICIAN: _____			WHO SENT PATIENT: _____		
OTHER PHYSICIAN(S): _____					
CHIEF COMPLAINT: (Required for all visits)			CURRENT MEDS: <input type="checkbox"/> None		
_____			_____		
_____			_____		
LMP ____/____/____	LAST PAP ____/____/____	ALLERGIES: <input type="checkbox"/> None			
LAST COLORECTAL SCREENING: ____/____/____			_____		
LAST MAMMOGRAM: ____/____/____			_____		
HISTORY OF PRESENT ILLNESS (HPI) Brief = 1-3 elements			Extended = 4+ elements or 3+ chronic/inactive conditions		
<input type="checkbox"/> New Problem		<input type="checkbox"/> Existing Problem			
Elements: Location; Quality; Severity; Duration; Timing; Context; Modifying Factors; Associated Signs & Symptoms					

PAST, FAMILY, SOCIAL HISTORY (PFSH)					
Pertinent PFSH= 1 specific item from <u>either</u> Past, Family or Social History					
Complete PFSH= New patient: 1 specific item from past, family and social history					
Established patient: 1 specific item from 2 of the 3 history areas (past, family or social history)					
FAMILY HISTORY (FH):		<input type="checkbox"/> Non-Contributory		<input type="checkbox"/> No Interval Change since ____/____/____	
Mother: <input type="checkbox"/> Living	<input type="checkbox"/> Deceased	Cause _____	Father: <input type="checkbox"/> Living	<input type="checkbox"/> Deceased	Cause _____
Siblings: Number Living _____	Number Deceased _____	Cause(s) _____			
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Hyperlipidemia _____			
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Hypertension _____				
<input type="checkbox"/> Other _____					
PAST HISTORY (PH):		<input type="checkbox"/> Non-Contributory		<input type="checkbox"/> No Interval Change since ____/____/____	
# Pregnancies ____ Births ____					
Surgeries: _____					
Illness(es): _____					
Injuries: _____					
Immunizations: _____					
Vaccinated for HPV: Y ____ or N ____ Dates: _____ Interested in HPV vaccination: Y ____ or N ____					
SOCIAL HISTORY (SH):		<input type="checkbox"/> Non-Contributory		<input type="checkbox"/> No Interval Change since ____/____/____	
Tobacco Use: <input type="checkbox"/> No	<input type="checkbox"/> Yes _____				
Alcohol/Drugs Use <input type="checkbox"/> No	<input type="checkbox"/> Yes _____				
Domestic Violence: <input type="checkbox"/> No	<input type="checkbox"/> Yes _____				
Seat Belt Use <input type="checkbox"/> No	<input type="checkbox"/> Yes _____				
<input type="checkbox"/> Diet Discussed _____		Reg. Exercise: <input type="checkbox"/> No <input type="checkbox"/> Yes _____			
<input type="checkbox"/> Other _____					