New Patient/ Annual Visit Health Update:

We appreciate your cooperation and patience as we transition to electronic health records. Please assist us by updating the following:

Name: _____Date of Birth: _____Age: _____Race/Nationality:_____

E-mail Address: _____Primary Phone Number:_____

Marital Status:_____ Number of Total Pregnancies:_____ Number of Children:_____

Current Medical Diagnoses (e.g. HTN, Diabetes)_____

Past Surgeries:_____

Current Medications:_____

Family History (e.g. Cancer/Diabetes/Heart Disease)_____
- any family history of: Breast Cancer Ovarian Cancer Uterine Cancer Colon Cancer

Allergies: _____ Tobacco Use: Current Former Never **Alcohol Use/Week:_____**

Preferred Pharmacy:_____

Women's Health Update:

Contraception Update:

Current Contraception_____ Length of Use: _____
When are you planning on having another child? Not Ready Yet W/In 3-5 years W/In 10 years Family is Complete

Cycle Update:

Last Menstrual Cycle:_____ # of days:_____ Irregular Spotting Between Cycles?:_____
Does your period impact your daily activities? _____

Urinary Health:

Do you leak urine when you cough, sneeze, laugh? _____ Do you urinate more than 6x/day? _____
Do you have trouble making it to the restroom in time? _____Do you have trouble starting or stopping your stream?_____

Wellness Questionnaire:

At WHW we are not only interested in health but overall wellness. Wellness is an active process of becoming aware of and making choices toward a healthy and fulfilling life. Please help us to target your wellness goals.

Check off any of the following symptoms you have experienced in the past 6 months:

- ☐ Tension/Headaches
- ☐ Always Tired
- ☐ Difficulty Sleeping
- ☐ Digestive Problems
- ☐ Fibromyalgia
- ☐ Carpal Tunnel
- ☐ Chronic Pain
- ☐ Hormone Problems
- ☐ Hair Loss/Thinning
- ☐ Sweating/Hot Flashes
- ☐ Allergies/Sinus Problems:
- ☐ Fatigue
- ☐ Bloating/Gas
- ☐ Irritable Bowel Syndrome
- ☐ Constipation
- ☐ Anxiety
- ☐ Depression
- ☐ Headaches
- ☐ Eczema
- ☐ Circles under the eyes
- ☐ Auto-immune reaction

How long have you had it?_____What does it feel like ?(describe) _____

What have you done that has helped this problem? _____

Does this cause you to be:

- ☐ Moody
- ☐ Irritable
- ☐ Interrupt sleep
- ☐ Restricted in your daily activities

Does this affect your work:

- ☐ Decision making
- ☐ Poor attitude
- ☐ Decreased productivity
- ☐ Exhausted at the end of the day
- ☐ Unable to work long hours

Does this affect your life:

- ☐ Lose patience with spouse/children
- ☐ Restricted household duties
- ☐ Hinders ability to exercise
- ☐ Interferes with ability to do hobbies

Current Hormone Therapy: _____ Weight Loss/ Concerns: _____

Do you desire Nutrition Guidance/Exercise Guidance?:_____

Further Concerns for Physician:

_____