



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:

- | | | |
|--|--|---|
| <input type="checkbox"/> Tension/Headaches | <input type="checkbox"/> Hormone Problems | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Always Tired | <input type="checkbox"/> Hair Loss/Thinning | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Sweating/Hot Flashes | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Allergies/Sinus Problems: | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Bloating/Gas | <input type="checkbox"/> Circles under the eyes |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> 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

Decision making

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

Lose patience with spouse/children

- Restricted household duties
- Hinders ability to exercise
- Interferes with ability to do hobbies

Does this affect your life:

Does this affect your work:

Current Hormone Therapy: _____ Weight Loss/ Concerns: _____

Do you desire Nutrition Guidance/Exercise Guidance?: _____

Further Concerns for Physician: _____