Solutions Pharmacy

Phone: (423) 894-3222 / Toll Free:(800) 523-1486
Fax: (423) 499-8435 / Toll Free Fax: (877) 890-8435
Hours: M-F: 9am-7pm

Female Patient Information

Name: _____ Today's Date: _____
LAST MIDDLE FIRST

Date of Birth: _____ Social Security #: _____

Street address: _____

City: _____ State: _____ Zip: _____

Phone numbers: Home _____ Cell _____

Do you have an email address you can share with us? _____

Patient employed by: _____

Business address: _____

Business phone: _____

Marital status: (please circle) Married Divorced Single Widow Living with Sig. Other

Spouse's Name: _____
FIRST LAST

In case of emergency, whom should we notify? _____

Phone number(s): _____

Signature: _____ Date: _____

What is the reason for your visit today? If it is a problem, please describe the symptoms & be specific: _____

_____

OB HISTORY

1. How many times have you been pregnant? ..... _____
2. How many miscarriages have you had? ..... _____
3. How many abortions have you had? ..... _____
4. Have you had any Tubal/Ectopic pregnancies? ..... _____
5. How many vaginal deliveries have you had?..... _____
6. How many Cesarean Sections have you had?..... _____
7. Have you had any premature deliveries? ..... _____
8. Have you had any babies weighing less than 5 lb 8 oz at birth? ..... _____
9. How many full term deliveries? ..... _____
10. Have you had any twin births?..... _____
11. Did you have any complications with your pregnancies? ❑ YES ❑ NO
    If yes, list: _____

_____

_____

GYN HISTORY

1. Are you sexually active? ❑ YES ❑ NO
1a. Have you been sexually active? ❑ YES ❑ NO
2. Do you have pain with intercourse? ❑ YES ❑ NO
3. What type of contraception are you currently using? (CIRCLE BELOW)

   Pills Tubal Ligation Condoms Withdrawal Depo Provera IUD
   Foam Vasectomy Diaphragm Implants Other _____

4. What type of contraception have you used in the past? (CIRCLE BELOW)

   Pills Tubal Ligation Condoms Withdrawal Depo Provera IUD
   Foam Vasectomy Diaphragm Implants Other _____

5. Are you having any problems with your method of Birth Control? ❑ YES ❑ NO
6. Have you ever had any vaginal, cervical and/or tubal infection? ❑ YES ❑ NO
   If yes, please check below:
   ❑ Yeast ❑ Gardnerella ❑ Syphllis ❑ Condyloma ❑ Bacterial Vaginitis ❑ PID
   ❑ Herpes ❑ Trichomonas ❑ Chlamydia ❑ Gonorrhea ❑ Warts ❑ Other _____
7. **Date of last pap smear?** _____
8. Have you ever had an abnormal pap smear? ❑ YES ❑ NO
   If yes, how was it treated? Please check below:
   ❑ Repeated Pap Smear ❑ Colposcopy ❑ Laser Surgery ❑ Cone Biopsy
   ❑ Cryosurgery (freezing) ❑ Hysterectomy ❑ Loop Excision
9. Do you have trouble leaking urine? ❑ YES ❑ NO

10. Do you have any breast lumps, tenderness or discharge? ❑ YES ❑ NO
10a. Have you had a mammogram? ❑ YES ❑ NO
If yes, was it normal? ❑ YES ❑ NO
Date of last mammogram_____
11. Do you do breast self exams? ❑ YES ❑ NO
12. Do you have PMS symptoms? ❑ YES ❑ NO
If yes, any treatment?_____
13. Do you have any hot flashes or menopausal symptoms? ❑ YES ❑ NO
14. Do you have any uterine anomalies? ❑ YES ❑ NO
15. Do you have a history of infertility? ❑ YES ❑ NO
16. Do you have a history of DES exposure? ❑ YES ❑ NO

MENSTRUAL HISTORY

1. If you no longer have periods, please state reason:_____
2. First day of last period:_____
3. How many days does your period last? _____
4. Are your periods regular? ❑ YES ❑ NO
5. How many days from the start of one period to the start of the next period? _____
6. Has the flow changed in any way? _____ If so, how? _____
7. Do you have any bleeding between periods? ❑ YES ❑ NO
8. Do you have any cramping with your periods? ❑ YES ❑ NO
If yes, circle one: mild moderate severe
9. Medicine taken for cramps? _____

SOCIAL HISTORY

1. Do you smoke cigarettes? ❑ YES ❑ NO
If yes, # per day? _____ Number of years? _____
2. Do you use street drugs? ❑ YES ❑ NO
3. Do you drink alcohol? ❑ YES ❑ NO
If yes, how much per day?_____

FAMILY HISTORY

1. Do you have a family history of breast cancer? ❑ YES ❑ NO
   If yes, whom?_____
2. Do you have a family history of colon cancer? ❑ YES ❑ NO
   If yes, whom?_____
3. Do you have a family history of ovarian cancer? ❑ YES ❑ NO
   If yes, whom?_____
4. Do you have a family history of osteoporosis? ❑ YES ❑ NO
   If yes, whom?_____
5. Do you have a family history of diabetes? ❑ YES ❑ NO
   If yes, whom?_____
6. Do you have a family history of hypertension? ❑ YES ❑ NO
   If yes, whom?_____
7. Do you have a family history of heart disease? ❑ YES ❑ NO
   If yes, whom?_____
8. Do you have a family history of kidney disease? ❑ YES ❑ NO
   If yes, whom?_____

CURRENT SYMPTOMS

Night Sweats	❑ YES	❑ NO	Dry Skin	❑ YES	❑ NO
Hot Flashes	❑ YES	❑ NO	Vaginal Dryness	❑ YES	❑ NO
Short term Memory Loss	❑ YES	❑ NO	Loss of Energy	❑ YES	❑ NO
Depression	❑ YES	❑ NO	Weight Gain	❑ YES	❑ NO
Irritability	❑ YES	❑ NO	Sleep Disruption	❑ YES	❑ NO
Nervousness	❑ YES	❑ NO	Leg Pain	❑ YES	❑ NO
Headaches	❑ YES	❑ NO	Hair Loss	❑ YES	❑ NO