Elizabeth Shadigian, MD Empowering WomanCare and Gynecology
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Date & time of first appointment________________________________

Please fill out as much of this form as you would like to. We will complete your health herstory together when we see you for your appointment. Please choose from any of the following to return this form: 1) bring it to your appointment 2)email the completed form to info@womansafehealth.com 3) fax to 734-477-5111

Name ____ Indicate Preferred Pronouns
Last First Middle

First name you prefer to use___________________________ Date of birth ______________________

Address ____
Street City State Zip

Preferred phone __________________________ Alternate phone ____

Email ______________________________ Preferred pharmacy & phone #__________________________________

Would you like to be added to our e-mail list to receive periodic updates on classes, groups, events and new program offerings at WomanSafeHealth? (please check): Yes / No

Would you like a reminder email for your next annual? Yes No If so, Month _______________ Year_________

Emergency contact person _________________________ Relationship _____________ Phone # _______________

Please bring insurance information with you, if you have any.

Insurance policy holder name_____________________________________ Policy holder date of birth____________

Insurance Company_____________________ Policy Number_________________ Group Number ________________

Name of person who referred you to WomanSafeHealth ____

Your occupation _______________________________________

Reason for your visit today

____
____
____

Health Herstory

Last medical visit and with whom ____
Primary health care provider _______________________ Address ___________________________________

Phone __________________________ Fax __________________________ (Info needed to send records)

Other health care providers ____

Last pap test results and date ____

Last cholesterol results and date ____

Last mammogram results and date ____

Do you do self breast exam? _______

For Office Use Only

Next Appointment ________________ Time Spent Together ___________ File To do Billing Dictation
Dictation Started Receipt (circle client preference) Email Printed Both Neither Billing Started Billing Completed

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Current medications and dosages, date started, reason for taking____

____

____

Current herbs/supplements/homeopathic medications, date started, reason for taking______________________

____

____

List any side effects to your current medications or supplements:____

____

Allergies and reactions ____

Major illnesses/diagnoses and dates____

____

____

Surgeries/hospitalizations and dates____

____

Gynecological Herstory

First day of Last Menstrual Period, if applicable ________________ regular, every _____ days; or irregular ____

How old were you when your periods first started _____ length of flow ______

Recent changes in your period/any problems____

Obstetrical Herstory

Any herstory of infertility? ________

Total number of pregnancies _______ Number of biological, adopted, foster or step-children _______________

Number of months or years you have breastfed a baby ___________________

Family Herstory

Please indicate if anyone in your immediate family has had any of the following and who it was (brother, sister, mother, father, maternal or paternal grandmother or grandfather):

Alcoholism/addiction

Anxiety

Breast/ovarian/endometrial cancer

Colon/prostate cancer

Depression/bipolar disorder

Diabetes

Heart disease/heart attack

High blood pressure

High cholesterol

Osteoporosis

Stroke/clots in legs or arms (DVT)

Suicide Attempts

Thyroid disease

Other

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Previous health care providers from whom you've sought treatment for mental health conditions. Treatments may include psychotherapy, counseling, psychiatric care, complementary/alternative therapies, hospitalizations, or intensive outpatient treatments (use back of page if you need more room):

Approximate Date	Name of Provider	Location	Type of Treatment	Helpful/Not Helpful

List any past psychiatric medications, herbs, and/or supplements (use back of page if you need more room):

Medication/ Supplement	Approximate Dates Taken	Dosage	Reason	Helpful/Not Helpful

Have you ever had head trauma of any kind (from falls, motor vehicle accidents, injury from another person, sports concussion, military combat, etc)? If so, please describe: ______________________________

Have you ever had a seizure? __________

Do you use caffeine (in the form of coffee, tea, pills, chocolate)? If yes, how much and how often?

____

Do you smoke/chew tobacco or use e-cigarettes? If yes, how much and how often? If you have quit, then how long ago?

____

Do you currently use alcohol? If so, how much and how often? ______________________________

____

Have you ever had a problem with alcohol use? If yes, please describe: ______________________________

____

Please list any other drugs you have used, and the nature of your use:

____

____

Highest grade (and degree, if applicable) completed: ______________________________

Any military service: ______________________________

Do you have a spiritual practice or religious faith? If so, please describe:

____

What are your strengths and gifts?

____

____

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Last Name, First Name   Date of Birth

Review of Systems

Please check any of the following symptoms you have experienced in the **last month**:

Constitutional

Weight loss   Fatigue   Fever   Anxiety   Depression/sadness   Other
Weight gain   Difficulty sleeping   Headaches   Anger/Irritability   Suicidal Thoughts

Eyes/Ear/Nose/Throat

Vision changes   Glasses/contacts
Sores   Drainage/congestion   Headache   Hearing loss   Other

Cardiovascular/Respiratory

Difficulty breathing while lying on back   Difficulty breathing on exertion
Chest pain   Swelling   Palpitations   Other
Wheezing   Shortness of breath   Cough   Coughing up blood

Gastrointestinal

Diarrhea   Constipation   Bloody stool   Nausea/vomiting/indigestion
Flatulence (gas)   Pain   Fecal incontinence (losing stool)

Genitourinary

Blood in urine   Pain when urinating   Urinary frequency   Abnormal or painful periods
Incomplete emptying   Urinary urgency   Can't hold urine
Vaginal dryness   Pain with sex   Hot flashes/flushes
PMS   Abnormal vaginal bleeding   Unusual vaginal discharge

Musculoskeletal

Muscle weakness   Muscle or joint pain   Other

Skin

Rash   Sores   Pigmented lesions   Dry skin   Other

Breast

Breast pain   Discharge   Masses   Other

Neurologic

Fainting spells   Seizures   Numbness   Trouble walking   Memory problems   Other

Endocrine

Hot flashes   Hair loss   Heat/cold intolerance   Very thirsty   Other

Other

Swollen lymph nodes   Bruises   Unusual Bleeding   Allergic reaction
Illness(es)

Other symptoms I'm concerned about...

___
___
___
___
___
___
___

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