



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 _____ 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

High blood pressure

Anxiety

High cholesterol

Breast/ovarian/endometrial cancer

Osteoporosis

Colon/prostate cancer

Stroke/clots in legs or arms (DVT)

Depression/bipolar disorder

Suicide Attempts

Diabetes

Thyroid disease

Heart disease/heart attack

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?

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	Palpitations
Wheezing	Cough
Swelling	Other
Shortness of breath	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
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Skin

Rash	Sores	Pigmented lesions	Dry skin	Other
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Breast

Breast pain	Discharge	Masses	Other
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Neurologic

Fainting spells	Seizures	Numbness	Trouble walking	Memory problems	Other
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Endocrine

Hot flashes	Hair loss	Heat/cold intolerance	Very thirsty	Other
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Other

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

Other symptoms I'm concerned about...

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