Lakeview Women's Health

Patient Information

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Date of Birth: _____ Age: _____

Marital Status: Married Single Widowed Divorced

Email Address: _____

Referred By / How did you hear about us: _____

Preferred Provider (Circle One): June Franzen / Heather Anderson / No Preference / First Available

Responsible Party

Name: _____ Relationship: _____

Date of Birth: _____Social Security Number: _____

Primary Insurance

Insurance: _____

Address: _____

Phone: _____ Fax: _____

Subscribers Name: _____ Date of Birth: _____

Relationship to Subscriber: _____ ID#: _____

Secondary Insurance

Insurance: _____

Address: _____

Phone: _____ Fax: _____

Subscribers Name: _____ Date of Birth: _____

Relationship to Subscriber: _____ ID#: _____

Prescription Insurance: _____

Reason for Today's Visit:

When did you first notice the symptoms & **LAST MENSTRUAL PERIOD:**

What treatment have you received:

Name of the Doctor(s) that have treated you:

Exercise on a daily basis? None Moderate Heavy

Do you Smoke? Yes If Yes, Please Specify: _____ No Former

Do you drink Alcohol? Yes Drinks per week: _____ None

Has anyone ever told you to cut down on your drinking? Yes No

Do you use drugs for reasons that are not medical? Yes No

Surgical History

Have you had a Hysterectomy? Yes No If Yes, Why: _____

Surgery:	**Date:**	**Reason:**	**Notes (If Any)**
Births:	**Gender / Weight:**	**Date:**	**Vaginal / C-Section**

Pregnancies _____ Abortions _____ Miscarriages _____ Multiple Pregnancies _____ Living _____

Personal History of Cancer? Yes No If Yes, Where/When: _____

Family History

Father: Alive Deceased Age: _____ Medical History: _____

Mother: Alive Deceased Age: _____ Medical History: _____

Sister: Alive Deceased Age: _____ Medical History:_____

Brother: Alive Deceased Age: _____ Medical History:_____

Children: _____ Ages: _____ Medical History: _____

Medications

Allergies: _____ Reaction: _____

Pharmacy: _____ Mail Order Pharmacy: _____

Medication	**Strength**	**Dosage**	**Frequency**
Example: Cipro	*250 mg*	*1 Tablet*	*2 x per day*

(For additional medications, please list on reverse side)

Date of Last Mammogram: _____ Date of Last Pap: _____

Date of Last DEXA: _____ Date of Last Colonoscopy: _____

Flu Vaccine: _____ Shingles Vaccine: _____ Pneumonia Vaccine: _____

Constitutional
Fatigue
Weight loss
Weight gain
Weakness
Chills/fever

Head
Dizziness
Headache
Pain
Fainting
Head injury

Eyes
Vision changes
Eye Pain
Eye infections
Cataracts
Glaucoma
Eye discharge/ Redness

Nose
Pain
Infection
Nasal obstruction
Allergies
Nose Bleed

Mouth
Mouth Pain
Tooth Pain
Voice changes
Hoarseness

Ears
Ear Pain
Discharge
Decreased Hearing
Hearing aid

Throat
Pain
Enlarged tonsils
Lumps

Respiratory
Asthma
Pain with breathing
Tuberculosis
Cough
Shortness of breath
Wheezing

Cardiovascular
Chest Pain
High Blood Pressure
Palpitations
Shortness of breath
Swelling of legs
Heart murmur
History of heart attack
Heart stents/surgery
Leg Pain
Leg Ulcers

Allergy
Coughing
Post nasal Drip
Itchy/ watery eyes
Runny Nose
Sneezing
Wheezing
Hives
Stuffy nose/congestion

Musculoskeletal
Arthritis
Gout
Joint Pain
Muscle Pain
Back Problems
Weakness

Skin
Dryness
Itching
Redness
Rash
Lumps
Hives
Changes in color/ texture

Psychiatric
Anxiety
Hallucinations
Memory Loss
Schizophrenia
Bipolar
Depression
Mood Changes
Excessive Stress

Neurological
Fainting
Tingling
Numbness
Burning
Memory Loss
Head Injury
Tremors
Dizziness
Headache
Stroke
Migraine

Gastrointestinal
Abdominal Pain
Change in stool
Hemorrhoids
Nausea
Trouble Eating/swallowing
Diarrhea
Gallbladder Disease
Hepatitis
Use of laxatives
Rectal bleeding
Vomiting
Constipation
Heart burn
Rectal pain
Vomiting blood

Hematology
Anemia
Easy Bruising
Bleeding Easily
Lumps/swollen glands
Blood Clots
Bleeding Disorders-Genetic

Endocrine
Cold/ Heat intolerence
Diabetes
Goiter
Thyroid trouble
Sweats
Increased Thirst
Neck pain

Female Urinary/Genitourinary
Awakening to Urinate
Blood in Urine
Burning
Cystocele
Difficulty Starting Stream
Excessive Urination
Flank pain
Frequency
Incontinence
Urinary infections
Painful Urination
Rectocele
Kidney Stones
Urgency

Female Genitalia
History of abnormal PAPs
Changes in Period
Discharge
Itching
Infertility
Lesions/lumps on genitals
Menopausal
Painful periods
Irregular Periods
Heavy Bleeding
Bleeding after Menopause
Pain with Intercourse
Sexually transmitted diseases
Vaginal Dryness
Sexual Problems

Breast
Breast Cancer
Pain/Tenderness
Discharge
Lumps