

Women's Health Care – Preventive Visit Update

Thank you for making an appointment with the Women's Health Care Center. Please take a moment to fill out this form and bring it with you to your appointment. All of your answers will be kept private.

Your name: _____ Your age: _____ Today's date: _____

Which type of visit are you here for today? (Check one):

- Full preventive health review and physical exam
 Breast and pelvic exam (with Pap smear) only

Please check any of the items below that you hope to arrange or talk about at this visit:

- Arrange
 Blood work Mammogram Colon cancer screening Vaccination(s)

- Prescription refills (including birth control)

How many days supply of one medicine does your insurance cover? (Please check one):

- 30 days 90 days Other: _____

- Talk about recent labs or other recent tests (Specify): _____

- Obtain referral(s) (Please specify): _____

- Other concerns or questions: _____

Please list all medicines, vitamins, herbs, and supplements you take or sometimes take:

Please list all medication allergies you have now or have had in the past:

Since your last general physical exam, have you had any:

- | Yes | No | If "Yes," please give details. |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Hospital stays, surgeries, or deliveries? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Medical care from doctors outside UWMC? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | New medical conditions? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Changes in job or living situation? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Changes in family's medical history? _____ |

Health Habits and Safety Concerns: (Please check appropriate box for each item below)

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke? If yes, indicate amount _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you consider your diet to be healthy? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a new sexual partner in the past year? |

How often, in the last year, have you had four or more alcoholic drinks on one occasion?

- Never Less than monthly Monthly Weekly Daily or almost daily

(Continued on Reverse)

PT.NO

NAME

DOB

Place EPIC Label Within Box

UW Medicine

Harborview Medical Center – UW Medical Center
Northwest Hospital & Medical Center – University of Washington Physicians
Seattle, Washington

WHCC PREVENTIVE VISIT HEALTH UPDATE



U2218

UH2218 REV SEP 05



Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

- Do you feel safe in your home and your relationship(s)?
- Have you been verbally or physically threatened or abused by anyone in the past year?
- Do you always wear your car seatbelt and a bike helmet when you ride?
- Is there a gun in your home?
- Do you exercise for more than 30 minutes four or more days a week?

Recent Problems

For each item below, please show whether you have had any recent problems by checking yes or no:

	Yes	No		Yes	No		Yes	No
General:			Intestinal:			Neurologic/psychiatric:		
Weight change without trying	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>
Unusual fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Weakness in limbs	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or passing out	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal bloating	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>
Awakening due to pain	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety or panic attacks	<input type="checkbox"/>	<input type="checkbox"/>
						Feeling depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>
Head/eyes/ears/throat:			Blood/growths:			Little interest in doing things	<input type="checkbox"/>	<input type="checkbox"/>
Changes in your eyesight	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding from gums	<input type="checkbox"/>	<input type="checkbox"/>			
Hoarse voice	<input type="checkbox"/>	<input type="checkbox"/>	Swollen lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	Joints, bones, and muscles:		
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Breast lump or pain	<input type="checkbox"/>	<input type="checkbox"/>	Muscle or bone pain	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	Lump or mass elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	Painful Joints	<input type="checkbox"/>	<input type="checkbox"/>
						Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>
Heart:			Skin:			Glands/endocrine:		
Palpitation	<input type="checkbox"/>	<input type="checkbox"/>	Non-healing sore(s)	<input type="checkbox"/>	<input type="checkbox"/>	Thirsty all the time	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Changing mole(s)	<input type="checkbox"/>	<input type="checkbox"/>	Can't stand heat or cold	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>						
			Gynecologic/urinary:			Do you have any other health		
Lungs:			Irregular or heavy periods	<input type="checkbox"/>	<input type="checkbox"/>	concerns that your provider		
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding after menopause	<input type="checkbox"/>	<input type="checkbox"/>	should know about today? If		
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	yes, please explain:	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	Pain with periods	<input type="checkbox"/>	<input type="checkbox"/>			
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Pain with intercourse	<input type="checkbox"/>	<input type="checkbox"/>			
			Unusual vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>			

Completed by: _____ Date: _____
 (Patient signature)

Thank you for filling this out!

Reviewed by:

PHYSICIAN/ARNP/PA SIGNATURE	PRINTED NAME	PAGER	NPI	DATE	TIME
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PT.NO _____

NAME _____

DOB _____

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