DaVita Medical Group
Women's Health

For Office Use Only: Date: _____ HT: _____ WT: _____ B/P: _____ /_____ R: _____ P: _____ Age: _____

Urine Results: Glu: _____ Ket: _____ Blood: _____ Protein: _____ Nitrites: _____ Leuk: _____

Your DaVita Medical Group medical record is becoming electronic.
Help us enter accurate information about you by answering the following questions:

| **Allergies** | | |
|---|---|---|
| **Medication, Food, or Substance (List below)** | **What happens? (Symptoms or reactions)** | **When did this occur?** |
| | | |
| | | |
| | | |
| | | |
| Do you have allergies to Latex? ❑Yes ❑No | | |
| Do you have allergies to Contrast Dye? ❑Yes ❑No | | |

| **Medications (Current)** | | |
|---|---|---|
| **Name of Medication** | **Dose/Frequency** | **Reason or Condition** |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

DaVita Medical Group Women's Health

| **Social History** (write answers and check spaces as needed)**:** | |
|---|---|
| Employment | ❑Full time ❑Part time ❑Retired ❑Unemployed ❑In School ❑Permanently Disabled ❑Partially Disabled<br>Your occupation: |
| Marital Status | ❑Single ❑Married ❑Divorced ❑Widow ❑Partner |
| Sexual Orientation | ❑Heterosexual ❑Same sex ❑Both sexes ❑Transgender ❑Other<br>Comments: |
| Sexually Active | ❑Yes ❑No ❑Same partner for ___years ❑Multiple partners<br>With ❑Males ❑Females ❑Both |
| Education | ❑High School ❑Bachelor's ❑Master's ❑Doctorate<br>❑or years completed: |
| Smoking | ❑Never ❑Previous (past) smoker ❑Recently stopped<br>❑Smoking now ❑# per day _____ for how many years _____<br>❑Quit (date) _____<br>❑Smoked ___packs per day for ___years ❑Chew tobacco<br>Frequency _____ |
| Alcohol | ❑Drink alcohol – Type: _____ Frequency: _____ ❑Never drink alcohol ❑Recovering alcoholic<br>❑Stopped drinking alcohol ❑Alcohol use during pregnancy |
| Caffeine | ❑No ❑Yes – how much _____ |
| Regular Exercise | ❑No ❑Yes – Type: _____ Frequency: _____ |
| Seatbelt Use | ❑Yes ❑No |
| Living in | ❑Home ❑Apartment ❑Hospice ❑Nursing home ❑Assisted living facility<br>❑Halfway house ❑Homeless ❑Also Homebound |
| Living Environment | ❑Secure and Safe ❑Fear of other Occupants |
| Leisure, Recreational or Sports Activities | |
| Learning Disability [PMH] | |
| Recreational Drug Use/Substance Abuse [PMH] | ❑No<br>❑Yes – Type:_____ Route: _____ Frequency: _____<br>❑Past Drug Abuse: ❑Yes ❑No |
| Are you on a special diet? | ❑No ❑Yes – **Details:** _____ |

| Name | |
|---|---|
| MRN | DOB |

DaVita Medical Group Women's Health

| **Past Medical History:** *ONLY CHECK YES IF APPLIES TO YOU* | | | | | |
|---|---|---|---|---|---|
| **History of:** | | **When?** | **History of:** | | **When?** |
| Alcohol Abuse Problem | ❑Yes | | Cancer Ovarian | ❑Yes | |
| Anemia | ❑Yes | | Cancer Uterine | ❑Yes | |
| Anxiety | ❑Yes | | Cancer Colorectal | ❑Yes | |
| Arthritis (Rheumatoid) | ❑Yes | | Cancer Lung | ❑Yes | |
| Arthritis (Osteo or Degenerative) | ❑Yes | | Cancer Colon | ❑Yes | |
| Asthma | ❑Yes | | Cancer Prostate | ❑Yes | |
| Bleeding Tendency | ❑Yes | | Cancer Skin Melanoma | ❑Yes | |
| Bladder/Urinary infection | ❑Yes | | Cancer Skin Basal Cell | ❑Yes | |
| Blood Clots: Legs (deep vein thrombosis) | ❑Yes | | Cancer Other | ❑Yes | |
| Blood clots: Lung (pulmonary embolus) | ❑Yes | | Cirrhosis | ❑Yes | |
| Blood Transfusion | ❑Yes | | COPD/Emphysema | ❑Yes | |
| Breast Problems | ❑Yes | | Cancer Lung | ❑Yes | |
| Cancer Breast | ❑Yes | | Diabetes | ❑Yes | |
| Depression | ❑Yes | | Low Back Pain | ❑Yes | |
| Epilepsy | ❑Yes | | Liver Disease Type: | ❑Yes | |
| Gall Bladder Disease | ❑Yes | | Migraine | ❑Yes | |
| Glaucoma | ❑Yes | | Multiple Sclerosis | ❑Yes | |
| Gout | ❑Yes | | Osteoporosis/ Osteopenia | ❑Yes | |
| Hay Fever | ❑Yes | | Pap Smear Abnormal | ❑Yes | |
| Heart Attack | ❑Yes | | Parkinson's Disease | ❑Yes | |
| Heart Disease | ❑Yes | | Pelvic Inflammatory Disease | ❑Yes | |
| Heart Failure | ❑Yes | | Parkinson's Disease | ❑Yes | |
| Heartburn/GERD/ Reflux | ❑Yes | | Kidney Stone | ❑Yes | |

| Name | |
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| **Past Medical History:** ***ONLY CHECK YES IF APPLIES TO YOU*** | | | | | | |
|---|---|---|---|---|---|---|
| **History of:** | | **When?** | | **History of:** | | **When?** |
| High Blood Pressure (Hypertension) | ❑Yes | | | Kidney Failure, Type: | ❑Yes | |
| High Cholesterol (Hypercholesterolemia) | ❑Yes | | | Shingles | ❑Yes | |
| Hives/Urticaria | ❑Yes | | | Skin Condition | ❑Yes | |
| Hepatitis B | ❑Yes | | | Sleep Apnea | ❑Yes | |
| Hepatitis C | ❑Yes | | | Stroke | ❑Yes | |
| | | | | Thyroid – Low (Hypothyroidism) | ❑Yes | |
| | | | | Sexually Transmitted Disease:<br>❑Chlamydia infection (penile or vaginal)<br>❑ Genital Herpes<br>❑ Gonorrhea<br>❑ Other venereal disease<br>❑ HPV | ❑Yes | |

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| **Family History** | | | | | |
|---|---|---|---|---|---|
| Do you have children? ❑Yes ❑No If yes, how many? | | | | | |
| **History of (check if "yes"):** | **Father** | **Mother** | **Brother** | **Sister** | **Other** |
| Alcohol Abuse Problem | ❑ | ❑ | ❑ | ❑ | ❑ |
| Alzheimer's/Dementia | ❑ | ❑ | ❑ | ❑ | ❑ |
| Arthritis | ❑ | ❑ | ❑ | ❑ | ❑ |
| Asthma | ❑ | ❑ | ❑ | ❑ | ❑ |
| Cancer, Breast | ❑ | ❑ | ❑ | ❑ | ❑ |
| Cancer, Ovarian | ❑ | ❑ | ❑ | ❑ | ❑ |
| Cancer, Uterine | ❑ | ❑ | ❑ | ❑ | ❑ |
| Cancer, Colorectal | ❑ | ❑ | ❑ | ❑ | ❑ |
| Cancer, Lung | ❑ | ❑ | ❑ | ❑ | ❑ |
| Cancer, Colon | ❑ | ❑ | ❑ | ❑ | ❑ |
| Cancer, Prostate | ❑ | ❑ | ❑ | ❑ | ❑ |
| Cancer, Skin Melanoma | ❑ | ❑ | ❑ | ❑ | ❑ |
| Cancer, Skin Basal Cell | ❑ | ❑ | ❑ | ❑ | ❑ |
| Cancer, Other | ❑ | ❑ | ❑ | ❑ | ❑ |
| Depression | ❑ | ❑ | ❑ | ❑ | ❑ |
| Diabetes | ❑ | ❑ | ❑ | ❑ | ❑ |
| Hay Fever | ❑ | ❑ | ❑ | ❑ | ❑ |
| Heart Attack | ❑ | ❑ | ❑ | ❑ | ❑ |
| High Blood Pressure (hypertension) | ❑ | ❑ | ❑ | ❑ | ❑ |
| High Cholesterol (hypercholesterolemia) | ❑ | ❑ | ❑ | ❑ | ❑ |
| Liver Disease, Type: | ❑ | ❑ | ❑ | ❑ | ❑ |
| Migraine | ❑ | ❑ | ❑ | ❑ | ❑ |
| Kidney Failure, Type: | ❑ | ❑ | ❑ | ❑ | ❑ |
| Stroke | ❑ | ❑ | ❑ | ❑ | ❑ |
| Other: | ❑ | ❑ | ❑ | ❑ | ❑ |

| **Adult Prevention History** | | |
|---|---|---|
| **Test** | **Test Result** | **Where & Approx Date** |
| Bone Density (BXA) | | |
| BRCA Testing | | |
| Mammography | | |
| Pap Smear | | |
| Colon cancer screen with colonoscopy, barium enema, flexible sigmoidoscopy or stool cards | | |

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| **Adult Prevention History (Cont.)** | | |
|---|---|---|
| **Test** | **Test Result** | **Where & Approx Date** |
| Colorectal Screening | | |
| If you have asthma, COPD or emphysema: Pulmonary Function (Breathing) Test | | |
| If you have diabetes: Foot Exam ❑Yes ❑ No<br>Dilated eye examination ❑Yes ❑ No | | |
| **VACCINATIONS:** | | |
| H1N1 (Swine Flu) | ❑Yes ❑ No | |
| Hepatitis A | ❑Yes ❑ No | |
| Hepatitis B | ❑Yes ❑ No | |
| Herpes zoster (shingles) | ❑Yes ❑ No | |
| Human Papillomavirus (HPV) | ❑Yes ❑ No | |
| Influenza (Flu) | ❑Yes ❑ No | |
| Measles, Mumps, Rubella (MMR) | ❑Yes ❑ No | |
| Meningococcal | ❑Yes ❑ No | |
| Pneumococcal (pneumonia) | ❑Yes ❑ No | |
| Tetanus or Tetanus/diphtheria (Td) or Tetanus/Diphtheria/Pertussis (Tdap) | ❑Yes ❑ No | |
| Varicella (chicken pox) | ❑Yes ❑ No | |

| **Past Surgical History** | | |
|---|---|---|
| **Surgery:** | **Description (if known):** | **Approx. Date** |
| Appendix | | |
| Bladder | | |
| Blood vessel | | |
| Eye | | |
| Ear | | |
| Gall Bladder | | |
| Heart | | |
| Joint | | |
| Pelvic | | |
| Prostate | | |
| Stomach | | |
| Skin | | |
| Uterus (Cesarean, Hysterectomy) | | |
| Other | | |

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| **Current Female Health History** | | | | |
|---|---|---|---|---|
| Last pap smear | Date:<br>Results: | Number of pregnancies | | |
| Last mammogram | Date:<br>Results: | Number of deliveries | | |
| Age @ Menstrual Period | | Number of Miscarriages/ abortions | | |
| 1st Day of Last menstrual period | Date: | Method of contraceptive/ how long? | ❑Yes | Type:<br><br>Any Problems with Method? |
| Frequency of Periods | | Gynecologic Problem | ❑Yes | |
| Irregular or missed menstrual periods | ❑Yes | Menopausal | ❑Yes<br>How Long? | |

| **Current Male Health History** | | | | |
|---|---|---|---|---|
| Prostate Problem<br>Type: | ❑Yes | Have you been counseled about the pros/cons of PSA prostate cancer screening? | ❑Yes<br>Date: | |
| Urine Flow Problem | ❑Yes | Have you had a prostate biopsy? | ❑Yes<br>Date: | Results: |

| **Review of Systems** | **DATE: _____** | |
|---|---|---|
| **Patient: please check below if you have any of the following problems:** | | |
| **SYSTEM** | **DESCRIPTION** | **PROVIDER COMMENTS (Document for all positive findings)** |
| **1. General**<br>❑ *No Problems* | **❑ Weight Loss # lbs: ____ ❑ Weight Gain # lbs: ____**<br>**❑ Fever ❑ Other:** | |
| **2. Eyes**<br>❑ *No Problems* | **❑ Glasses/Contact Lenses ❑ Vision Changes**<br>**❑ Other:** | |
| **3. Head & Neck Ears, Nose, Mouth, Throat**<br>❑ *No Problems* | **❑ Headache ❑Stiffness ❑ Ringing in Ears**<br>**❑ Sinus Infections ❑ Mouth Sores**<br>**❑ Other:** | |

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| **Patient: please check below if you have any of the following problems:** | | |
|---|---|---|
| **4. Heart/Circulation**<br>❑ *No Problems* | ❑ **Difficulty Breathing when lying down**<br>❑ **Swelling in legs** ❑ **Irregular heart rate**<br>❑ **Other:** | |
| **5. Lungs/Breathing**<br>❑ *No Problems* | ❑ **Shortness of breath** ❑ **Wheezing**<br>❑ **Coughing up blood**<br>❑ **Other:** | |
| **6. Digestion/Bowels**<br>❑ *No Problems* | ❑ **Nausea/Vomiting** ❑ **Gas** ❑ **Constipation**<br>❑ **Diarrhea** ❑ **Bloody Stools**<br>❑ **Other:** | |
| **7. Kidneys/Bladder**<br>❑ *No Problems* | ❑ **Blood in Urine** ❑ **Painful Urination**<br>❑ **Urgency** ❑ **Frequent Urination** ❑ **Incomplete Emptying** ❑ **Incontinence**<br>❑ **Other:** | |
| **8. Reproductive**<br>❑ *No Problems* | ❑ **Abnormal Bleeding** ❑ **Pain with Intercourse**<br>❑ **Other:** | |
| **9. Muscles/bones**<br>❑ *No Problems* | ❑ **Muscle Weakness**<br>❑ **Other:** | |
| **10. Skin/Breasts**<br>❑ *No Problems* | ❑ **Rash** ❑ **Itching** ❑ **Breast Pain** ❑ **Discharge**<br>❑ **Lump** ❑ **Bleeding**<br>❑ **Other:** | |
| **11. Nervous System**<br>❑ *No Problems* | ❑ **Fainting** ❑ **Seizures** ❑ **Numbness**<br>❑ **Problems Walking**<br>❑ **Other:** | |
| **12. Mental/Emotional**<br>❑ *No Problems* | ❑ **Anxiety** ❑ **Crying** ❑ **Depression** ❑ **Insomnia**<br>❑ **Other:** | |
| **13. Endocrine**<br>❑ *No Problems* | ❑ **Diabetes – Type: _____**<br>❑ **Hot flashes** ❑ **Low Thyroid**<br>❑ **Overactive Thyroid**<br>❑ **Other:** | |
| **14. Blood/Lymphatic**<br>❑ *No Problems* | ❑ **Bruises** ❑ **Clotting Problems**<br>❑ **Swollen Lymph Nodes**<br>❑ **Other:** | |
| **Reason for Visit Today: _____**<br>**Health Concerns Today: _____** | | |
| **Completed by:** ❑ **Patient** ❑ **Other – Relationship to Patient: _____** | | |
| Additional Provider Comments: | | |
| | | |
| | | |

| Name | |
|---|---|
| MRN | DOB |