Women's Health Care Group
OBSTETRICS & GYNECOLOGY

870 Palisade Avenue, Suite 301
Teaneck, NJ 07666
Phone: 201.907.0900
Fax: 201.907.0229
whcgnj.com

Patient Information

Name: ______________________ Today's Date: ____ /____ /______

Date of Birth: ____ /____ /______ Age: ______ Social Security #: _____–____–________

Occupation: ______________ Marital Status: ❍ Single ❍ Married ❍ Widowed ❍ Separated ❍ Divorced

Referring Doctor: ______________________ Phone: (______) ______–__________

Updated Medical/Family History

❍Y ❍N Do you have any allergies? If yes, to what? ______________________

❍Y ❍N Do you drink alcohol? If yes, what kind? ____________ How much? ____________ How often? ________

❍Y ❍N Have you ever smoked?

❍Y ❍N Do you smoke presently? If yes, how many cigs/day ____________ # years smoking ____________

❍Y ❍N Past illnesses and/or surgeries (include dates) ______________________

____

❍Y ❍N Serious illnesses in your family (i.e. diabetes, high blood pressure, cancer, heart disease, other) ____________

____

❍Y ❍N Are you taking any medications? Please list names and dosages below:

______________________ ______________________

______________________ ______________________

Review of Symptoms

*Are you experiencing any of the following? Check **Y** (yes) or **N** (no).*

Symptoms	*Eyes*	*Neurological*	*Endocrine*
❍Y ❍N Fever	❍Y ❍N Blurred vision	❍Y ❍N Tremors	❍Y ❍N Excessive thirst
❍Y ❍N Chills	❍Y ❍N Double vision	❍Y ❍N Dizzy spells	❍Y ❍N Too hot /cold
❍Y ❍N Headaches	❍Y ❍N Eye pain	❍Y ❍N Numbness	❍Y ❍N Tired / sluggish
❍Y ❍N Weight loss / gain	❍Y ❍N Glasses / contacts	❍Y ❍N Fainting	❍Y ❍N Hair loss
❍Y ❍N Loss of height	❍Y ❍N Other __________		
Gastrointestinal	***Cardiovascular***	***Skin / Lymph***	***Musculoskeletal***
❍Y ❍N Abdominal pain	❍Y ❍N Chest Pain	❍Y ❍N Rash	❍Y ❍N Joint pain
❍Y ❍N Nausea / vomiting	❍Y ❍N Varicose Veins	❍Y ❍N Boils	❍Y ❍N Neck pain
❍Y ❍N Indigest / heartburn	❍Y ❍N High blood pressure	❍Y ❍N Persistent itch	❍Y ❍N Back pain
❍Y ❍N Bloody stool	❍Y ❍N Fast / irreg heartbeat	❍Y ❍N Swollen glands	
❍Y ❍N Change in bowels	❍Y ❍N Palpitations		
Ear / Nose / Mouth	***Urinary System***	***Respiratory***	***Psychological***
❍Y ❍N Ear infections	❍Y ❍N Incomplete empty	❍Y ❍N Wheezing	❍Y ❍N Are you sad?
❍Y ❍N Sore throat	❍Y ❍N Painful urination	❍Y ❍N Frequent cough	❍Y ❍N Depressed?
❍Y ❍N Sinus problems	❍Y ❍N Freq urination	❍Y ❍N Shortness of breath	❍Y ❍N Have you considered suicide?
❍Y ❍N Mouth sores	❍Y ❍N Incontinence		
	❍Y ❍N Blood in urine		

Breasts / Genital System

❍Y ❍N Breast pain	❍Y ❍N Pelvic pain	❍Y ❍N Vaginal itching	❍Y ❍N Painful intercourse
❍Y ❍N Heavy periods	❍Y ❍N Breast lumps	❍Y ❍N Vaginal pain	❍Y ❍N Vaginal sores / lesions
❍Y ❍N Missed periods	❍Y ❍N Discharge	❍Y ❍N Nipple discharge	❍Y ❍N Other ________
❍Y ❍N Irregular bleeding	❍Y ❍N Hot flashes	❍Y ❍N Decreased sexual desire	________________
❍Y ❍N Painful periods	❍Y ❍N Vaginal dryness		________________

Other: ______________________________________