Dr. Woods
WELLNESS

Name_____ Age_____ Date of Birth_____

Reason for Visit_____**Date**_____

Please list all current medications: (prescription and over the counter)

Medication	Dosage	Frequency	Reason

Please list all allergies: (medication, latex, food, environmental)

Allergy	Reaction

Past Medical History

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Blood Transfusion
- ☐ Cancer_____
- ☐ Depression
- ☐ Diabetes Mellitus I
- ☐ Diabetes Mellitus II
- ☐ Elevated Cholesterol
- ☐ Fibromyalgia
- ☐ Gastrointestinal Disorder
- ☐ GERD
- ☐ Heart Attack
- ☐ Gluten Sensitivity
- ☐ Heart Disease
- ☐ Headache/Migraine
- ☐ High Blood Pressure
- ☐
- ☐ HPV
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hematologic Disorder
- ☐ Osteoporosis
- ☐ Problems with Anesthesia
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ History of STD_____
- ☐

Surgical History:

Please list all surgeries and hospitalizations:

Date	Operation	Complications

Social History:

Occupation: _____

Marital Status:

□ Single □ Married □ Domestic Partner □ Divorced □ Widowed

Are you currently sexually active?

□ Yes □ Not Currently □ Never

Current sexual partner is:

□ Male □ Female

Alcohol Use:

□ Yes □ No

Drinks per week: _____

Tobacco Use:

□ Current □ Former □ Never

If yes, how many packs per day? _____

Do you use recreational drugs?

□ Current □ Former □ Never

Do you have a history of domestic violence?

□ Yes □ No

If yes please explain: _____

Family History

	Mother	Father	Brother	Sister	Grandmother Maternal	Grandfather Maternal	Grandmother Paternal	Grandfather Paternal	Aunt	Uncle
Arthritis										
Blood Clots										
Breast Cancer										
Cervical Cancer										
Diabetes										
Elevated Cholesterol										
Heart Attack										
Heart Disease										
High Blood Pressure										
Osteoporosis										
Ovarian Cancer										
Stroke										
Uterine Cancer										
Prostate Cancer										
Other Cancer										
Other Disease										

Female History

First day of last period_____

Current method of birth control_____

Age at first period_____

How many days between periods_____

How many days do your periods last_____

Do you have concerns about your period?_____

Number of pregnancies:_____

Number of full term deliveries (past 37 weeks):_____

Number of premature deliveries (prior to 37 weeks):_____

Number of miscarriages:_____

Number of terminations:_____

Number of living children:_____

	Birthdate	Weeks Gestation	# hours In labor	Sex	Vaginal or C-Section	Complications	Location of Birth
1							
2							
3							
4							
5							
6							
7							