DR WISEMAN PATIENT VISIT FORM

Patient Name _____

Date of birth _____ /_____ / _____

Primary Care Provider _____

Pharmacy of Choice _____ Location _____

Visit Date: ____ /_____ /_____

Brief reason for visit today:

_____

_____

gynecologic history

Are you having periods? 0 Yes 0 No If yes, 1st day of last period: ___ / ___ /_____

When was your last Pap smear? ____ /____ /_____ Was it normal? 0 Yes 0 No

Have you ever been treated for an abnormal pap smear? 0 Yes 0 No

Have you ever had a Mammogram? 0 Yes 0 No Date of most recent ____ /____ /_____

Are you currently using anything for birth control? 0 Yes 0 No

If yes,

0 Tubal occlusion/removal 0 Vasectomy
0 Intrauterine device 0 Nexplanon
0 Nuvaring 0 Condoms
0 Natural Family planning
0 Birth control pill Name _____

obstetric history (skip if no history of pregnancy)

How many times have you been pregnant? ____

How many times Have you delivered a full term baby? ____

How many times have you delivered A preterm Baby? ____

How many times have you experienced a Miscarriage? ____

How many living children do you Have? ____

How many of your deliveries were by Cesarean section ____

Have you ever had an ectopic pregnancy? 0 Yes 0 No

If applicable, how much did the largest of your newborns weigh? ____ lbs ____ oz.

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MEDICAL HISTORY

In the **past year**, has a medical problem led to you

a) being seen in the ER? 0 Yes 0 No b) being hospitalized? 0 Yes 0 N

Are you **currently** being treated/evaluated for any medical problems? 0 Yes 0 No

If Yes, Please indicate conditions:

0 Hypertension 0 Diabetes 0 Heart/Vascular disease 0 Thyroid disease

0 Autoimmune Disorders 0 Elevated cholesterol/lipid abnormalities 0 Asthma

0 Cancer 0 Gastrointestinal Disorders 0 Neurologic disorders

0 Anxiety/depression 0 Bleeding disorders 0 kidney stones 0 Infection

0 Other _____

SURGICAL HISTORY

Have you ever undergone surgery? 0 Yes 0 N

If yes, please indicate below

0 Appendectomy 0 Tonsillectomy 0 Cholecystectomy (gallbladder)

0 Cesarean section 0 Tubal ligation or excision (BTL) 0 Endometrial ablation

0 Hysterectomy 0 Removal of ovary, ovaries, or ovarian cyst(s)

0 Orthopedic or podiatry procedures 0 Thyroid surgery 0 Spine/brain surgery

0 Incontinence surgery 0 Breast augmentation 0 "Tummy tuck" or Liposuction

0 Heart surgery or catheterization procedure

0 Other _____

_____

Besides nausea/vomiting, have you had problems with anesthesia? 0 Yes 0 No

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MEDICATION ALLERGIES

Do you have any allergies to medications? 0 Yes 0 No

List medications which have led to a rash, hives, swelling, or breathing difficulty

_____ _____ _____ _____

CURRENT MEDICATIONS

_____ _____ _____ _____

_____ _____ _____ _____

FAMILY HISTORY

Mother —> 0 Alive 0 Deceased at age ____.

Medical Problems: _____

_____

Father —> 0 Alive 0 Deceased at age _____.

Medical Problems: _____

_____

Sibling(s) —> Medical Problems: _____

_____

Do you have grandparents, aunts, uncles, or cousins with any of the following?

0 Breast cancer 0 Ovarian cancer 0 Uterine cancer 0 Colon cancer

SOCIAL HISTORY

Marital status _____

Occupation_____

Currently smoke? 0 Yes 0 No . If yes, ____ cigs / day. Smoking since age _____

Currently vape? 0 Yes 0 No. If yes, ____ ecigs / day. Vaping since age _____

Marijuana use? 0 Yes 0 No . If yes, _____ times per month

Alcohol use? 0 Yes 0 No. If yes, _____ drinks per month

Other recreational drug use? 0 Yes 0 No

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SYMPTOM REVIEW

General -

Have you recently experienced unintended weight loss?	0 Yes 0 No
Have you had ongoing problems with unexplained fatigue or weakness?	0 Yes 0 No
Have you been experiencing fevers, sweats, or chills?	0 Yes 0 No

Gynecologic -

Are you experiencing irregular or heavy vaginal bleeding?	0 Yes 0 No
Are you experiencing vaginal itching, burning, or new discharge?	0 Yes 0 No
Are you experiencing worsening or consistent pain with menses	0 Yes 0 No
Are you experiencing pain with intercourse (if applicable)	0 Yes 0 No
Are you experiencing new or worsening pelvic or abdominal "Pressure" ?	0 Yes 0 No

Bladder -

Are you experiencing Pain with urination?	0 Yes 0 No
Are you having to rise more than twice at night to urinate?	0 Yes 0 No
Do you have difficulty going 2 hours without having to urinate?	0 Yes 0 No
Do you have difficulty urinating?	0 Yes 0 No
Do you lose urine with cough, sneeze, or physical activity?	0 Yes 0 No
Have you noticed blood in you urine?	0 Yes 0 No

Gastrointestinal -

Are you experiencing nausea or vomiting?	0 Yes 0 No
Are you experiencing loss of appetite?	0 Yes 0 No
Are you experiencing chronic diarrhea	0 Yes 0 No
Have you noticed blood when having a bowel movement?	0 Yes 0 No
Has your stool become narrow or "pencil-like" ?	0 Yes 0 No

Breasts -

Have you noticed any new breast lumps?	0 Yes 0 No
Have you noticed any lumps in your arm pits?	0 Yes 0 No
Are you experiencing any Pain in the Breasts?	0 Yes 0 No
Have you noticed any unexplained nipple discharge?	0 Yes 0 No
Have you noticed in changes in the skin of the breasts?	0 Yes 0 No

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