Circle of Life
Women's Center

1525 E. 6000 S. Suite A
South Ogden, UT 84405
Phone: (801) 337-5800
Fax: (801) 337-5809
www.colwc.com

Circle of Life Women's Center is happy you have chosen us for your care! To make your upcoming appointment more efficient for you as well as your provider, we ask that you fill out the following health history. You will notice it also includes areas for the problem you wish to address at your visit and your current medication & supplement list. Please bring this completed document to your appointment so that our staff may meet your needs more accurately. If you need additional space for any of the sections below, please attach a separate sheet. ***Before being taken to our Registration area, this document will need to be completed in its entirety.**

Name: _____ DOB: _____

What is the reason for your visit: _____

MEDICAL HISTORY

Please mark all that apply below.

___ No Known Medical History Problems

	You	Family	Details/Comments
AIDS (HIV)	□	□	_____
Anemia/Blood Disorder	□	□	_____
Asthma	□	□	_____
Blood Clots	□	□	_____
Blood Transfusions	□	□	_____
Breast Disease	□	□	_____
Cancer (If yes, who & what type?)	□	□	_____
Depression/Anxiety (If yes, family history of depression or suicide?)	□	□	_____
Diabetes	□	□	_____
Female/Sexual Problems	□	□	_____
Gall Bladder	□	□	_____
Heart Disease/Stroke/Heart Attack	□	□	_____
Hepatitis	□	□	_____
High Blood Pressure	□	□	_____
High Cholesterol	□	□	_____
Infertility	□	□	_____
Kidney/Bladder/UTI	□	□	_____
Liver Disease	□	□	_____
Neurologic/Epilepsy	□	□	_____
Psychiatric	□	□	_____
Pulmonary Disease	□	□	_____
Rheumatic Fever	□	□	_____
Seasonal Allergies	□	□	_____
Sexual/Domestic Abuse	□	□	_____
Stomach or Bowel	□	□	_____
Thyroid Disease	□	□	_____
Tuberculosis	□	□	_____
Varicose Veins	□	□	_____

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SUBSTANCE USE

	Yes	No	Details/Comments
Alcohol	□	□	_____
Tobacco	□	□	_____
Recreational Drugs	□	□	_____

SEXUAL HISTORY

	Yes	No
Have you ever been sexually active?	□	□
Sexual Concerns:		
Pain with intercourse	□	□
Bleeding with intercourse	□	□
Have you had a new partner in the past year?	□	□
Have you ever had any of the following STD's:		
Chlamydia	□	□
Genital Herpes	□	□
Gonorrhea	□	□
Hepatitis C	□	□
HPV (Cervical Dysplasia or Genital Warts)	□	□
Syphilis	□	□
Trichomonas	□	□
HIV	□	□

Other Sexual Concerns? _____

LIFESTYLE

	Yes	No
Have you ever had a PAP test?	□	□
If yes, have you ever had an abnormal PAP?	□	□
If yes, did you have a Cryo Surgery (freezing of cervix)?	□	□
If yes, did you have a Colposcopy (biopsy of cervix)?	□	□
Have you ever had a mammogram?	□	□

If yes, when & where? _____
If yes, results (if known)? _____

Do you have breast implants?	□	□
Have you ever had a dexascan?	□	□

If yes, when, where, & results? _____

Have you ever had a colonoscopy?	□	□

If yes, when, where, & results? _____

Do you perform monthly self breast exams?	□	□
Do you exercise on a regular basis?	□	□

How many hours of sleep do you receive each night? _____
How often do you wake during the night? _____

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MENSTRUAL HISTORY

	Yes	No
Are you post menopausal?	☐	☐
Have you had a hysterectomy?	☐	☐
Have you had an ablation?	☐	☐

When was the first day of your last period? _____
What was your age of first menses? _____
What is your interval between periods (# of days)? _____
What is your length of your periods (# of days)? _____

Do you have spotting in between your periods?	☐	☐
Do you have any abnormalities?	☐	☐
Excessive Bleeding	☐	☐
Pain	☐	☐
Unusual Discharge	☐	☐

Other Comments/Concerns: _____

BIRTH CONTROL

Current Contraceptive Method:

- ☐ None
- ☐ Oral Contraceptive Pill
- ☐ IUD
- ☐ Depo Provera
- ☐ Nexplanon
- ☐ Nuvaring
- ☐ Condoms
- ☐ Tubal Ligation
- ☐ Essure
- ☐ Hysterectomy
- ☐ Post Menopausal
- ☐ Vasectomy
- ☐ Other: _____

How long have you used your current contraceptive method? _____
Are you satisfied with your current contraceptive method? Yes No
If no, explain? _____
Are you planning a pregnancy? Yes No Uncertain

SURGICAL HISTORY

	Yes	No	Details/Complications
Cardiac Surgery	☐	☐	_____
ENT (Ear/Nose/Throat) Surgery	☐	☐	_____
Lung Surgery	☐	☐	_____
Musculoskeletal Surgery	☐	☐	_____

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	Yes	No	Details/Complications
GU (Genitourinary) Surgery	▫	▫	_____
GI (Gastroenterology) Surgery	▫	▫	_____
GYN (Gynecology) Surgery	▫	▫	_____
Breast Surgery	▫	▫	_____
Other Surgery	▫	▫	_____

PREGNANCY HISTORY

Total # of Pregnancies: _____
# of Births at or past 37 weeks gestation: _____
# of Births less than 37 weeks gestation: _____
Forceps used? Yes No Vacuum used? Yes No
# of Cesarean Deliveries: _____
# of Miscarriages: _____
# of Abortions: _____
Did you have any of the following pregnancy complications:

	Yes	No	Details/Comments
Preterm labor	▫	▫	_____
Recurrent pregnancy loss	▫	▫	_____
Still birth	▫	▫	_____
Gestational diabetes	▫	▫	_____
High blood pressure or pre-eclampsia	▫	▫	_____
Twins or triplets	▫	▫	_____
Abnormal bleeding	▫	▫	_____
Very large baby	▫	▫	_____
Growth restricted baby	▫	▫	_____
Birth defect	▫	▫	_____
Other complications	▫	▫	_____

MEDICATIONS

Please list all of your current medications (prescribed & over the counter). Many medications have similar spelling so please confirm the list below with your actual medication bottles to ensure we update your records accurately. If you need additional space, please attach a separate sheet.

Name *(check spelling on bottle)*	**Dosage** *(strength)*	**Frequency** *(how often you take)*	**Route of Administration** *(ex. oral, injectable, etc.)*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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SUPPLEMENTS

Please list all of your current supplements. Many supplements have similar spelling so please confirm the list below with your actual supplement bottles to ensure we update your records accurately. If you need additional space, please attach a separate sheet.

Name *(check spelling on bottle)*	**Dosage** *(strength)*	**Frequency** *(how often you take)*	**Route of Administration** *(ex. oral, injectable, etc.)*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES

Please list all of your current allergies:

_____
_____
_____

VACCINATIONS

	Yes	No	Unknown
Have you ever been vaccinated for Hepatitis A or B?	□	□	□
Have you had a tetanus shot within the last 10 years?	□	□	□
Have you had the Gardasil series?	□	□	□

Please note your appointment is scheduled for an allotted amount of time. In order for us to remain on schedule, if there are multiple problems you need to address, please prioritize what you wish to discuss today. We will ask you to make a follow-up visit to continue our assessment & treatment for any remaining problems until we have assisted you with all of your concerns. Thank you for assisting us to give you our best & most efficient care!