



JOVE MEDICAL
women's health care

JOVE MEDICAL
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DATE: _____
NAME: _____ DOB: _____
REASON FOR VISIT: _____

Primary Care Provider/Physician: _____

GENERAL MEDICAL HISTORY

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? YES NO, PLEASE DESCRIBE: _____

ARE YOU TAKING ANY PRESCRIBED OR OVER THE COUNTER MEDICATION OR SUPPLEMENTS? YES NO, PLEASE LIST / DESCRIBE: _____

HAVE YOU EVER HAD SURGERY? YES NO DATE: _____ DESCRIBE: _____

PERSONAL MEDICAL HISTORY

CANCER YES NO TYPE: _____
DIABETES YES NO
HEART DISEASE YES NO
HEART ATTACK YES NO AGE: _____
HIGH BLOOD PRESSURE YES NO
STROKE YES NO
SEASONAL ALLERGIES YES NO TYPE: _____

FAMILY MEDICAL HISTORY

| | ALIVE? Y / N | AGE / AGE AT DEATH | MAJOR MEDICAL PROBLEMS: |
|-----|-----------------|-----------------------|-------------------------|
| MOM | _____ | _____ | _____ _____ _____ |
| DAD | _____ | _____ | _____ _____ _____ |

SIBLINGS WITH MAJOR MEDICAL PROBLEMS: AGE, DESCRIBE:

PLEASE LIST & DESCRIBE ANY OTHER MEDICAL HISTORY: _____

DO YOU SMOKE? YES NO PACKS PER DAY: _____ HOW MANY YEARS: _____ WOULD YOU LIKE TO QUIT? YES NO

DO YOU CONSUME ALCOHOL? YES NO _____ # OF DRINKS PER _____ DAY WEEK MONTH

DO YOU EXERCISE REGULARLY? YES NO # OF DAYS / WEEK _____ DURATION _____ ACTIVITIES: _____

WOULD YOU DESCRIBE YOUR DIET AS : VERY HEALTHY HEALTHY SOMEWHAT HEALTHY FAIR POOR

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR OVERALL DIET (check all that apply): UNRESTRICTED LOW FAT LOW CHOLESTEROL
 LOW SUGAR, SWEETS, CARBS LOW/NO DAIRY VEGETARIAN VEGAN OTHER (describe): _____

WHEN WAS THE LAST TIME YOU HAD YOUR CHOLESTEROL CHECKED?: _____ WAS IT WITHIN NORMAL LIMITS? YES NO

IF OVER 50 YEARS OLD, HAVE YOU HAD A COLONOSCOPY? NA YES NO DATE: _____ PROBLEM? _____

DO YOU SUFFER FROM ANY OF THE FOLLOWING:

SEVERE HEADACHES? YES NO DESCRIBE: _____

PAIN IN THE LEGS, CHEST, ABDOMEN, OR JOINTS? YES NO DESCRIBE: _____

TROUBLE FALLING OR STAYING ASLEEP? YES NO

FATIGUE / LACK OF ENERGY? YES NO

FEELING DOWN, DEPRESSED, OR HOPELESS IN THE LAST MONTH? YES NO

DECREASED INTEREST OR PLEASURE IN DOING THINGS YOU PREVIOUSLY ENJOYED? YES NO

FAMILY CONFLICT OR RELATIONSHIPS SOMETIMES HANDLED BY PUSHING, HITTING, OR CRUELTY? YES NO

GYN

FIRST DAY OF LAST PERIOD OR LAST YEAR IF POSTMENOPAUSAL: _____

ARE YOUR PERIODS REGULAR? YES NO IF NO, DESCRIBE: _____

ARE THEY PAINFUL? YES NO

ARE THEY HEAVY? YES NO

LENGTH OF PERIODS: _____

DO YOU HAVE ANY BLEEDING BETWEEN PERIODS? YES NO

OF PREGNANCIES: _____ NUMBER OF BIRTHS: _____ MISCARRAIGES: _____ ABORTIONS: _____ DATE OF LAST PREGANCY: _____

PREFERRED METHOD OF BIRTH CONTROL:

CONDOMS IUD NUVA RING RHYTHM PATCH PILLS (brand) _____ # of years on pills: _____ OTHER _____

ARE YOU HAVING ANY PROBLEMS WITH YOUR CURRENT METHOD OF BIRTH CONTROL? YES NO _____

DATE OF LAST PAP TEST: _____ HAVE YOU EVER HAD AN ABNORMAL PAP? YES NO DATE: _____ PROBLEM: _____

WAS A PROCEDURE REQUIRED? YES NO DESCRIBE: _____

DATE OF LAST MAMMOGRAM: _____ WHERE: _____

HAVE YOU EVER HAD AN ABNORMAL MAMMOGRAM? YES NO DATE: _____ PROBLEM: _____

DID YOU HAVE THE FOLLOWING BIOPSY CYST DRAINED SURGERY: (describe) _____ DATE: _____

HAVE YOU HAD A HYSTERECTOMY? YES NO OTHER GYNECOLOGICAL PROCEDURE? YES NO

DESCRIBE: _____

HAVE YOU EVER HAD A BONE DENSITY TEST? YES NO DATE: _____ FINDINGS: NORMAL OSTEOPENIA OSTEOPOROSIS

HOW MANY SEXUAL PARTNERS HAVE YOU HAD IN THE LAST 12 MONTHS? _____ IN YOUR LIFETIME? _____

DO YOU NOW OR HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE? YES NO WHEN? _____ TYPE? _____

IF YOU ARE OVER 40 YEARS OLD, DO YOU HAVE PROBLEMS WITH:

HOT FLASHES / NIGHT SWEATS?

YES

NO

DIFFICULTY REACHING SEXUAL CLIMAX?

YES

NO

DIFFICULTY SLEEPING?

YES

NO

MOOD SWINGS / IRRITABILITY?

YES

NO

PAIN WITH INTERCOURSE?

YES

NO

DIFFICULTY LOOSING OR MAINTAINING WEIGHT?

YES

NO

DECREASE IN INTEREST / ENJOYMENT OF SEX?

YES

NO

DIFFICULTY WITH CONCENTRATION/MEMORY?

YES

NO

IF POSTMENOPAUSAL OR OVER 50 YEARS OLD DO YOU TAKE ANY OF THE FOLLOWING:

CALCIUM MAGNESIUM VITAMIN D ESTROGEN PROGESTERONE TESTOSTERONE OTHER HORMONES OR SUPPLEMENTS:

(describe/list) _____

ARE YOU INTERESTED IN HORMONE REPLACEMENT THERAPY? YES NO