

Flourish Women's Wellness
Alisha Madrone, NP, CNM

Name: _____ DOB: _____ Date: _____

MENSTRUAL HISTORY

Age menses began: _____ Date of last menstrual cycle: _____ Was this cycle normal? _____
How often do you have menstrual cycles? _____ How many days do you bleed? _____
What color is the blood? _____ Do you have clots? _____ Do you have pain? _____
What do you find is helpful in dealing with the pain? _____

REPRODUCTIVE HISTORY

Number of pregnancies: _____ Number of miscarriages: _____ Number of abortions: _____
Names and ages of children: _____

Are you currently trying to get pregnant? _____ If so, how long have you been trying? _____
If you are currently trying to NOT get pregnant, what type of contraception are you using? _____

Are you happy with your method? _____

HEALTH SCREENING

When was your last annual exam/pap test? _____ Any history of abnormal results? _____
When was your last breast exam/mammogram? _____ Any history of abnormal results? _____

SOCIAL HISTORY

Are you currently partnered? _____ How long have you been with your partner? _____
Are you in a mutually monogamous partnership? _____
Do you have concerns about exposure to sexually transmitted infections? _____
Do you smoke cigarettes? How much and for how long? _____
Do you drink caffeine? What type and how often? _____
Do you drink alcohol? What type and how often? _____
Do you do any drugs? What type and how often? _____

MEDICATION AND SUPPLEMENT USE

Please list any medications you are currently taking:

Please list any supplements you are currently taking:

NUTRITION/EXERCISE

Please describe a typical day's diet:

In what ways and how often do you exercise?

REVIEW OF SYSTEMS: Please check the box to indicate that you have or have had the following conditions:

General

- Fatigue
- Weight concerns

Eyes

- Spots before eyes
- Visual changes

Ears/Nose/Throat

- Ringing in ears
- Sinus problems
- Frequent colds
- Nose bleeds
- Mouth sores

Cardiovascular

- Heart palpitations
- Chest pain
- Swelling in legs

Respiratory

- Asthma
- Shortness of breath
- Chronic cough

Gastrointestinal

- Diarrhea
- Constipation
- Heartburn
- Nausea/vomiting
- Blood in stool/spitting up blood

Urinary

- Pain with urination
- Urinary frequency or urgency
- Incomplete emptying of urine
- Uncontrolled loss of urine

Reproductive

- Irregular menses
- Heavy menses
- Painful menses
- Painful sexual intercourse
- Vaginal dryness
- Vulvar pain
- STDs
- Fibroids
- Ovarian cysts

Musculoskeletal

- Muscle weakness
- Joint pain

Skin/Breasts

- Breast pain
- Nipple discharge
- Breast changes/masses
- Ulcers/herpes
- Genital warts

Neurological

- Dizziness/Fainting
- Seizures
- Numbness
- Headaches/Migraines

Psychiatric

- Anxiety
- Depression
- Abuse
- Insomnia
- Suicide attempt(s)

Endocrine

- Diabetes
- Hyperglycemia
- Hypoglycemia
- Rashes/skin problems
- Abnormal thirst
- Hot flashes

Hematologic/Lymphatic

- Blood clots
- Easy bruising
- Enlarged lymph nodes

Allergic/Immunologic

- Food allergies
- Drug allergies
- Other allergies

Surgery/Hospitalizations

Family History

- Cancer _____
- Diabetes _____
- Heart Disease _____
- High Blood Pressure _____
- Kidney Disease _____
- Other _____

What would you like to discuss at our visit?
