Compassionate Care for Women
Lawson C Richter, MD

•Must Complete

Name: _____ Date: _____

Date Of Birth: _____ Age: _____ Marital Status: _____ Height: _____

Other Physicians (Past/Present): REQUIRED_____
First Name Last Name

***Reason for visit today**: _____
_____

Medical Problems (Past/Present): _____
_____

Smoke: ___Yes ___No Drink Daily: ___Yes ___No Drug Use: ___Yes ___No Safe Sex: ___Yes ___No
Your Periods Are: ___Regular ___Irregular But Predictable ___Irregular & Not Predictable ___Infrequent

How often do your periods occur? ____<21 Days ____24-26 Days ____29-31 Days ____32-34 Days ____>34 Days
How many days do you have a menstrual flow? _____ Age at first period? _____
Date of last menstrual period? _____ Hysterectomy: ___Yes ___No If Yes: Partial/Total
Were you taking birth control pills at the time? ___Yes ___No
How do you keep from getting pregnant? _____
Positive home pregnancy test? ___Yes ___No If yes, enter the date: _____

Symptoms Or Problems Associated With Menstrual Cycle:

___Breast tenderness prior to menstrual ___Cramps during the first 2-3 days ___Cramps during cycle ___Depression/Anger
___Headaches/Migraines ___Hot Flashes ___Irritability ___Mood changes ___ Unexpected bleeding
___Do you ever miss school or work due to your period ____Other_____

Pregnancy History:
Have you ever been pregnant? ___Yes ___No If yes, how many times total (including abortions)? _____

	Year	Hospital	Sex	Weight	Vaginal/C-Section
1					
2					
3					
4					
5					

What was your age at first intercourse? _____ How many sexual partners in your lifetime? _____
Are you currently sexually active? ____Yes ____No How many current sexual partners do you have? _____
Have you had a Pap Smear? ____Yes ____No If yes, when was your last Pap? _____
How many abnormal pap smears have you had? _____
When was your last Mammogram? _____
Do you perform self-breast exams regularly? ____Yes ____No

Please Indicate If You Have Ever Had Any Of The Following Screening Tests For Colon Cancer:

____Never Had One ____Barium Enema ____Colonoscopy ____Sigmoidoscopy ____Stool Screening

Name: _____

Surgical History:

Type of Surgery Date Outcome

_____

_____

_____

Any allergies to medications? ____Yes ____No

If yes what are you allergic to? _____

Are you currently taking any medications? ____Yes ____No

What medications are you taking? Dose?

1_____ 4_____

2_____ 5_____

3_____ 6_____

******If, as part of your treatment plan, your condition may require a transfusion with blood / blood by products – would you accept such a transfusion? Yes_____ / No_____ Initials _____***

If your position on transfusions changes during your care, please notify the physician immediately.

***Preferred Pharmacy**: _____

***Pharmacy phone# or cross streets:**_____

Family History:

Disease: _____ Fam. Member: _____

Disease: _____ Fam. Member: _____

Disease: _____ Fam. Member: _____

Disease: _____ Fam. Member: _____

Disease: _____ Fam. Member: _____