WOMEN'S HEALTH MEDICAL HISTORY

Name: _____ DOB: ___/___/_____ Today's Date: ___/___/_____

Primary Care Physician: _____ Pharmacy Name/Phone #_____

REASON FOR YOUR VISIT TODAY: _____

_____

At what age did menstruation begin? _____

What was the first day of your last menstrual period? ___/___/_____

Is your period usually: ❑ light ❑ moderate ❑ heavy (Please check)

Is your period regular or irregular? _____ How often? _____

How many days does your period last? _____

If you have begun menopause at what age did you start? _____

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS:

❑ Anemia	❑ Asthma	❑ Stroke	❑ Thyroid Problems	❑ Depression/Anxiety
❑ Mental Illness	❑ High Blood Pressure	❑ Heart Problems	❑ Kidney Problems	❑ Blood Clots
❑ Diabetes Type 1	❑ Migraines	❑ Osteoporosis	❑ Kidney Stones	❑ Hypertension
❑ Diabetes Type 2	❑ Hepatitis Type: _____		❑ Other: _____	

	DATE	WHERE	RESULTS
Pap Smear			
Bone density scan			
Colonoscopy			
Mammogram			

PLEASE CHECK IF YOU HAVE HAD ANY OF THE BELOW SURGERIES:

❑ Bladder Surgery	❑ Appendectomy	❑ Thyroidectomy	❑ BSO
❑ Breast Surgery/Mastectomy	❑ Ovarian Cyst Removal	❑ Tubal Ligation	❑ C-Section
❑ Breast Augmentation	❑ Lap Hysterectomy	❑ Gallbladder	❑ Laparoscopy
❑ Total Abdominal Hysterectomy	❑ Total Vaginal Hysterectomy	❑ LEEP/Conization	❑ D&C

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HAS ANYONE IN YOUR FAMILY EVER HAD ANY OF THE FOLLOWING?

	Mother	Father	Sibling	Child	Other
Osteoporosis					
Heart Problems					
Stroke					
Uterine Cancer					
Bladder Cancer					
Breast Cancer					
Diabetes Type 1					
Diabetes Type 2					
High Cholesterol					
Alzheimer's					
Ovarian Cancer					
Thyroid Problems					
High Blood Pressure					
Colon Cancer					

Other: _____

Would you be interested in a genetic screening that tests for breast, colon and ovarian cancer? ❑ Yes ❑ No

Have you received the Gardasil vaccine series? ❑ Yes ❑ No

If so, when did you receive the last vaccine? _____ What series are you on? Please circle. 1 2 3

Have you received the Flu Vaccine? ❑ Yes ❑ No If so, when? _____

SOCIAL/REPRODUCTIVE HISTORY: Check all that apply.

General:

Marital status: ❑ Married ❑ Divorced ❑ Widowed ❑ Single ❑ Domestic Partner

Exercise amount per week: _____

Do you perform self-breast exams? ❑ Yes ❑ No If yes, how often? _____

Are you currently sexually active? ❑ Yes ❑ No

What do you currently use for birth control? Please check all that apply.

❑ IUD-date inserted ___/___/_____ ❑ Vasectomy ❑ Depo Provera ❑ Tubal Ligation ❑ Pills

IUD Type: _____ ❑ Condoms ❑ Nuva Ring ❑ None

WOMEN'S HEALTH MEDICAL HISTORY

Have you ever been pregnant? ❑ Yes ❑ No

How many living children do you have? _____

Have you had? ❑ Twins ❑ Triplets ❑ More ❑ N/A

How many of the following have you had?

Ectopic pregnancies _____ Abortions _____

Full term births _____ Premature births _____

Miscarriages _____

Substance Use:

Smoking and/or tobacco use: ❑ Past/Date quit: _____ ❑ Present Packs per day: _____ ❑ Never

Alcohol use: ❑ Never ❑ Occasionally/Socially ❑ Regular use- Drinks per day_____

Drug use (ex. cocaine, marijuana, meth, narcotics, and prescription drugs): ❑ Past ❑ Present ❑ Never

If yes, what type of drugs? _____ If yes, how often? _____

Caffeine use: ❑ Yes ❑ No How many drinks per day: _____

History of Abuse:

	Yes	No	Past
Do you ever feel like you are verbally or emotionally abused?	❑	❑	❑
Are you in a relationship where you are being slapped, hit or kicked?	❑	❑	❑
Are you ever forced to have sex when you do not want to?	❑	❑	❑

GYN HISTORY: Check all that apply.

Have you ever had any of the following?

❑ Abnormal pap ❑ Fibroids ❑ Endometriosis

❑ Infertility ❑ Ovarian Cyst ❑ Cancer Type: _____

Have you ever had any sexually transmitted diseases?

❑ Chlamydia ❑ Gonorrhea ❑ Trichomonas ❑ Genital Warts ❑ Pelvic Inflammatory Disease

❑ HPV ❑ HIV ❑ Hepatitis C ❑ Syphilis

Are you allergic to any medications? If yes, please list the medication as well as your reaction.

_____

_____

_____

Are you allergic to any of the following? ❑ Latex ❑ Iodine ❑ Nickel

WOMEN'S HEALTH MEDICAL HISTORY

MEDICATION LIST: *Please list all medications including over-the-counter*

Name of Medication	Dosage	Times per day	Prescribing Doctor
Example: Lasix	20 mg	Twice a day	Dr. Jones

REVIEW OF SYSTEMS: Please check all that you are ***currently*** experiencing.

Genital/Urinary:

- ❑ Breakthrough Bleeding
- ❑ Urinary Urgency
- ❑ Heavy Vaginal Bleeding
- ❑ Pain/Burning with Urination
- ❑ Vaginal Dryness
- ❑ Urinary Leakage
- ❑ Irregular Vaginal Bleeding
- ❑ Urinary Tract Infections
- ❑ Painful Intercourse
- ❑ Painful Periods
- ❑ Frequent Urination at Night

Endocrine:

- ❑ Hot Flashes
- ❑ Night Sweats
- ❑ Absense of Menstrual Periods
- ❑ Fatigue
- ❑ Hair Loss

Skin/Breasts:

- ❑ Changes in Mole
- ❑ Nipple Discharge
- ❑ Breast Lumps
- ❑ Breast Tenderness

Neurological:

- ❑ Frequent Headaches
- ❑ Muscle Weakness
- ❑ Poor Coordination
- ❑ Trouble Sleeping
- ❑ Moodiness

Digestive:

- ❑ Rectal Bleeding
- ❑ Diarrhea
- ❑ Constipation
- ❑ Significant Weight Gain _____ lbs
- ❑ Heart Burn
- ❑ Bloody Stool
- ❑ Black/Tarry Stool
- ❑ Significant Weight Loss _____ lbs
- ❑ Vomiting

Cardiac:

- ❑ Fainting/Dizziness
- ❑ Irregular Heartbeat
- ❑ Chest Pain

Respiratory:

- ❑ Shortness of Breath
- ❑ Coughing Up Blood
- ❑ Wheezing

Eyes:

- ❑ Changes in Vision