Women's Health Group
Patient History Form

Name: _____ **Date:** _____ **DOB:** _____

MARITAL STATUS (CIRCLE) SINGLE MARRIED DIVORCED SEPARATED

ALLERGIES

☐ None ☐ Latex ☐ Codeine ☐ Morphine ☐ Penicillin ☐ Sulfa ☐ Iodine ☐ Aspirin ☐ Foods ☐ Bee Stings ☐ OTHER

MEDICATIONS: **Please bring all medication bottles with you to your visit. This includes all OTC medications**

PREVIOUS SURGERIES or PROCEDURES (indicate approximate date)

☐ Appendectomy	☐ Laparoscopy	☐ Obesity Surgery (gastric bypass)
☐ Colonoscopy _____(yr)	☐ Tubal ligation	☐ Lithotripsy (kidney stone)
☐ Gallbladder	☐ Hysteroscopy	☐ Orthopedic surgery (Back, knee, hip, etc)
☐ Tonsillectomy	☐ Endometrial ablation	☐ Thyroid surgery
☐ Dental	☐ Hysterectomy, partial or total	☐ Sinus surgery
☐ Breast	☐ Ovaries- removal of one or both ovaries	☐ Heart Surgery
☐ Cosmetic surgery	☐ Urethral stretching	☐ Hernia repair
☐ D & C	☐ Bladder surgery	☐ Hemorrhoid surgery

LIST ALL OTHER SURGERIES OR HOSPITALIZATIONS

MEDICAL HISTORY (Indicate date)

☐ Anemia	☐ Colon polyps	☐ Heart Attack	☐ Rheumatoid Arthritis
☐ Anesthesia problems	☐ Crohn's Disease	☐ Heart Murmur	☐ Reflux (GERD)
☐ Anxiety Disorder	☐ Celiac Disease	☐ Hearing problems	☐ Sleep Apnea
☐ Asthma	☐ Depression	☐ Hepatitis	☐ Schizophrenia
☐ Attention Deficit Disorder	☐ Depression, postpartum	☐ High Cholesterol	☐ Skin Disorder
☐ Allergies	☐ Diabetes	☐ High blood pressure	☐ Stroke
☐ Bipolar Disorder	☐ Epilepsy (seizures)	☐ Irritable Bowel	☐ Stomach Ulcer
☐ Blood Clot in legs/lungs	☐ Glaucoma	☐ Kidney Disease	☐ Thyroid Disorder
☐ Blood Transfusion	☐ Headaches, chronic	☐ Kidney Stones	☐ Tuberculosis
☐ Cancer of any type	☐ Headaches , migraine	☐ Lupus	☐ Varicose Veins
☐ Chemical dependence or substance abuse		☐ Mitral valve prolapse	☐ Weight Problems
☐ Chronic Pain requiring treatment		☐ Osteoarthritis	
☐ Chronic Fatigue Syndrome		☐ Osteoporosis	

FAMILY HISTORY

☐ **I was adopted** ☐ **I do not know my family history**

	Mother	Father	Child(ren)	Sister(s)	Brother(s)	Aunt/Uncle	Grandparents
Breast cancer	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐
Ovarian cancer	☐	☐	☐	☐	☐	☐	☐
Uterine cancer	☐	☐	☐	☐	☐	☐	☐
Cervical cancer	☐	☐	☐	☐	☐	☐	☐
Cancer, other	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐
Genetic disease	☐	☐	☐	☐	☐	☐	☐

REVIEW OF SYSTEMS Please circle any of the SYMPTOMS below that you **are currently experiencing**.

Fever	Weight loss			
Vision problems	Blurred vision	Hearing problems	Nose bleeds	Ringing in ears
Rashes	Changes in skin moles	Unusual hair growth or hair loss		
Breast lumps	Breast pain	Discharge from nipples		
Chest pain	Palpitations/ irregular heart rate	Ankle swelling	Heart murmur as an adult	Coughing up blood
Shortness of breath		Chronic cough		
Abdominal pain- upper	Abdominal pain - lower	Bloody or black tarry stool	Diarrhea	Constipation
Nausea/Vomiting	Bloating	Flatulence/gas	Changes in Appetite	Heartburn
Urinary frequency	Urinary urgency	Painful urination	Bloody urine	Urine leakage
Difficulty starting urination		Getting up frequently at night to urinate		
Muscle aches	Joint aches	Back pain	Stiffness	
Headaches	Seizures	Blackouts or fainting spells	Memory disturbance	Numbness in extremities
Cold intolerance	Heat Intolerance	Excessive thirst	Hair /loss	Hot flashes Night Sweats
Anxiety/panic	Depression	Inability to concentrate	Suicidal thoughts	
Easy bruising	Prolonged bleeding	Swollen glands		

Alcohol Use	☐ Never used	☐ I quit using alcohol	☐ Social drinker	☐ Less than 2 days/week	☐ Daily
Tobacco Use	☐ I have never used tobacco products	☐ I quit using tobacco products	☐ I use tobacco products	☐ **I would like to quit smoking**	
Illicit Drug Use	☐ I have never used illicit drugs	☐ I quit using illicit drugs	☐ I use illicit drugs	☐ I have used IV/ injection drugs	☐ I have or have had a drug problem
Education	Are you a student? ☐ Middle school ☐ High School ☐ College	☐ High school graduate	☐ GED	☐ College graduate	☐ Master's degree or higher
Occupation	☐ Employed, full time	☐Employed, part	☐ Unemployed	☐ Disabled	☐ Retired

MENSTRUAL HISTORY

How old were you when you had your first menstrual period? _____

If you have been through menopause, how old were you at that time? _____ ☐ surgical ☐ natural

First day of last menstrual period: _____

Are your periods regular? ☐ YES ☐ NO please explain: _____

How long does your **NORMAL** period usually last (first bleeding until last bleeding)? _____(# days)

How far apart are your periods (first day of period to the first day of next)? _____

My menstrual flow is: ☐ LIGHT ☐ MODERTE ☐HEAVY ☐HEAVY WITH CLOTS

Cramping with my periods is: ☐ NONE ☐MILD ☐MODERATE ☐ SEVERE

Are you having any bleeding **between** menstrual periods? ☐ NO ☐ YES Do you bleed after sex? ☐ NO ☐ YES

CURRENT BIRTH CONTROL METHOD

☐ Pills ☐ Nuvaring ☐ Patch ☐ Implanon ☐ Depo-provera (shot) ☐ Mirena IUD ☐ Paragard IUD ☐ Tubal/ Vasectomy ☐ HYSTERECTOMY	☐ Condoms ☐ Diaphragm/ cervical cap ☐ Suppository, film, foam ☐ Withdrawal (pull out) ☐ Abstinence ☐ No method ☐ Trying to get pregnant

Methods you have used in the past (check all and write in years of use)

☐ Pills ☐ Nuvaring ☐ Patch ☐ Implant (Implanon, Norplant) ☐ Depo-provera (shot) ☐ Mirena IUD ☐ Paragard IUD	☐ Condoms ☐ Diaphragm/ cervical cap ☐ Suppository, film, foam ☐ Withdrawal (pull out) ☐ Abstinence ☐ No method ☐ Emergency contraceptive pills (Plan B)

GYNECOLOGICAL HISTORY

Have you had the Vaccine Series (Gardasil/ Cervarix) for prevention of cervical cancer and genital warts? ☐ NO ☐ YES

Are you sexually active? ☐ Never ☐ YES ☐ Not now, but have been in the past ☐ I plan to become sexually active

Do you have pain with intercourse? ☐ NO ☐YES Do you have any sexual problems or concerns? ☐ NO ☐ YES

When was your last pap smear? (for women 21 and older) _____ (year) ☐ Normal ☐ Abnormal

Have you had an abnormal pap smear in the past? ☐ NO ☐ YES

When was your last mammogram (for women over 40)? _____(year) ☐ Normal ☐ Abnormal

Have you have a bone mineral density test (DEXA)? ☐ NO ☐ YES

Did your mother take medication (DES) to prevent a miscarriage when she was pregnant with you? ☐ NO ☐ YES

If you have gone through menopause, have you ever used hormone therapy? ☐ NO ☐ YES

Have you been ☐ physically, ☐ sexually, or ☐ emotionally abused? ☐ NO ☐ YES

HAVE YOU HAD ANY OF THE FOLLOWING GYNECOLOGICAL CONDITIONS – USE SPACE FOR ALL OTHERS

☐ Infertility (trouble getting pregnant) ☐ Endometriosis ☐ Colposcopy (for evaluation of abnormal pap smear) ☐ **Dysplasia** (precancerous cells on cervix) ☐ Cryosurgery for treatment of dysplasia ☐ LEEP for treatment of dysplasia ☐ Laser treatment for treatment of dysplasia	☐ Genital Warts (HPV) ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Syphilis ☐ Pelvic Inflammatory Disease ☐ Recurrent Vaginal Infections ☐ Recurrent bladder (UTI) infections (3 or more a year)	☐ Ovarian Cysts ☐ Uterine Fibroids ☐ Polycystic Ovarian Syndrome (PCOS) ☐ Interstitial Cystitis ☐ Urine Leakage ☐ Do you lose urine when coughing or sneezing?

PREGNANCIES (include all pregnancies, miscarriages, abortions, ectopic pregnancy, stillbirths)
Include problems such as: premature, preterm labor, preeclampsia, gestational diabetes, etc

Preg	Year	# weeks pregnant at delivery	Female/ male	Birth weight	Cesarean or vaginal	Place of delivery	Doctor	Problems
1st								
2nd								
3rd								
4th								
5th								
6th								

Patient Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____