Womens Health History Form

Name: _____

Date: _____ Last Menstrual Period: _____

Return patients complete sections in box:

Reason for today's visit? _____

_____

Current Medications: _____

_____

_____

Has there been a change in your medical history?
□ No □ Yes, please explain _____

_____

Has there been a change in your surgical history?
□ No □ Yes, please explain _____

_____

New patients please complete this entire questionnaire

Current Medications: _____

_____

_____

Medication Allergies: _____

Past Medical History: (Check major significant illnesses that apply)

_____	Anemia	_____	Emotion/Mental illness
_____	Asthma	_____	Colitis
_____	Arthritis	_____	Epilepsy/Seizures
_____	Kidney Stones	_____	Liver Disease
_____	Osteoporosis	_____	Tuberculosis
_____	Thyroid Disease	_____	Ulcers
_____	Bleeding disorder	_____	Glaucoma
_____	Breast Cancer	_____	Hay Fever
_____	Migraines	_____	Stroke
_____	Cancer	_____	Heart Problems
_____	Hepatitis/Jaundice	_____	Diabetes
_____	High Blood Pressure	_____	Kidney Disease
_____	Depression	_____	HIV/AIDS

Surgeries/Operations/Procedures: (Please list year of surgery)

_____	Appendix	_____	Hip Surgery
_____	Breast Surgery	_____	Hysterectomy
_____	Uterine ablation	_____	Knee Surgery
_____	C-Section Delivery	_____	Plastic Surgery
_____	Colonoscopy	_____	Polyp Removed
_____	D & C	_____	Hernia
_____	GallBladder Surgery	_____	Thyroid Surgery
_____	Bladder Surgery	_____	Tonsils/Adenoids
_____	Laparoscopy	_____	Tubal Ligation
_____	Heart Surgery	_____	Other _____

Family History: — Which Relative? (Check/Circle those that apply)

Heart Disease	□ Father/Mother	□ Sibling	□ Child	□ Grandmother/father	□ Other
Osteoporosis	□ Father/Mother	□ Sibling	□ Child	□ Grandmother/father	□ Other
Diabetes	□ Father/Mother	□ Sibling	□ Child	□ Grandmother/father	□ Other
High Cholesterol	□ Father/Mother	□ Sibling	□ Child	□ Grandmother/father	□ Other
Blood Clots/DVT	□ Father/Mother	□ Sibling	□ Child	□ Grandmother/father	□ Other
Thyroid Disease	□ Father/Mother	□ Sibling	□ Child	□ Grandmother/father	□ Other
Breast Cancer	□ Father/Mother	□ Sibling	□ Child	□ Grandmother/father	□ Other
Uterine Cancer	□ Father/Mother	□ Sibling	□ Child	□ Grandmother/father	□ Other
Cervical Cancer	□ Father/Mother	□ Sibling	□ Child	□ Grandmother/father	□ Other
Ovarian Cancer	□ Father/Mother	□ Sibling	□ Child	□ Grandmother/father	□ Other
Colon Cancer	□ Father/Mother	□ Sibling	□ Child	□ Grandmother/father	□ Other
Other Cancer	□ Father/Mother	□ Sibling	□ Child	□ Grandmother/father	□ Other
Bleeding Prob.	□ Father/Mother	□ Sibling	□ Child	□ Grandmother/father	□ Other
Genetic Prob.	□ Father/Mother	□ Sibling	□ Child	□ Grandmother/father	□ Other

Reason for today's visit? _____

_____

May we leave normal lab results on a voicemail/answering machine? □Yes □ No

Social History:

Marital Status: □ Married □ Single □ Widowed □ Divorced
Occupation: _____
How many days a week do you exercise? _____
What do you do for exercise? _____
Tobacco Use _____ **Amount** _____ **Years of Use** _____
Alcohol Use? □ Never □ Rare □ Occasional □ Social □ Frequent
Drug Use? □Yes □ No If yes what? _____
History Abuse? □Yes □ No If yes check below:
□ Physical □ Sexual □ Emotional □ Verbal □ Other

Gynecological History:

Regular monthly cycles? □Yes □ No # of days of bleeding? _____
Any problems with periods? _____

Current method of contraception/birth control? _____

Any problems with birth control in the past? _____

Previous sexually transmitted disease? _____

Any new partners in the last 6 months? □Yes □ No

Date of last PAP smear? _____ **Normal □Yes □ No**
Previous abnormal PAP smear? □Yes □ No If yes, when? _____
Have you had a surgery/procedure for abnormal pap? □Yes □ No
If yes, What was done? _____
Normal PAP smears since procedure? □Yes □ No If no explain _____

Are you menopausal? □ Yes □ No □ Unsure

Have you taken Hormone Replacement Therapy?

If yes, for how long? _____

Any problems with hormones or medication? _____

Any Sexual Concerns? _____

Obstetrical History:
Number of pregnancies? _____

Any preterm deliveries (< 37 weeks) _____

Miscarriages? _____

Abortions? _____

Living children? _____

Any complications with Pregnancy? _____

Review of Systems: (Check if present)

_____	Change in Weight	_____	Blood in Urine
_____	Fever	_____	Muscle Weakness
_____	Fatigue/Tired	_____	Burning with Urination
_____	Vision Change	_____	Frequency/Urgency
_____	Glasses/Contacts	_____	Incontinence of Urine
_____	Chest Pain	_____	Vaginal Discharge
_____	Palpations	_____	Menstrual Cramps
_____	Leg Swelling	_____	Pain with Sex
_____	Wheezing	_____	Bleeding after Sex
_____	Short of Breath	_____	Sexual Difficulties
_____	Cough	_____	Abnormal Bleeding
_____	Diarrhea	_____	Rash/Change in Mole
_____	Bloody Stool	_____	Breast Mass/Pain
_____	Nausea/Vomiting	_____	Depression/Anxiety
_____	Constipation	_____	Hot Flashes
_____	Abdominal Pain	_____	Easy Bruising

SEE BACK SHEET FOR PREVENTION HISTORY OR ALL NEW PATIENTS AND ANNUAL EXAMS