Name:	
Chart #:	DOB:
Primary Care Provider:	
Referring Care Provider:	

WOMEN'S HEALTH HISTORY FORM

Please fill out the following pages regarding your healthcare and bring to your next appointment. This form will become a part of your medical record and will be kept in the same confidentiality. Your health is very important to us. Thank you.

Name *(Last, First, M.I.):*		**Age**	**Date of birth**
Marital status:	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered		
Occupation:		**Education (last grade completed):**	
Reason for visit:		**Date of last physical exam & where:**	

If you have specific concerns that you would like to discuss more with your health care provider, <u>please list them here by ranking them from highest priority to lowest priority</u>. We will do our best to accommodate them during your time allotted office visit. If not, we would be glad to assist you in arranging an additional appointment.

1. ____
2. ____
3. ____
4. ____
5. ____

Last Pap:	_______ (date) **Normal** ☐ **Abnormal** ☐	**Last cholesterol check:**	_______ (date) **Normal** ☐ **Abnormal** ☐
		Last colo-rectal screening:	_______ (date) **Normal** ☐ **Abnormal** ☐
Last Mammogram:	_______ (date) **Normal** ☐ **Abnormal** ☐	**Last bone mineral density:**	_______ (date) **Normal** ☐ **Abnormal** ☐

GYNECOLOGIC HISTORY

Date of last menstrual period:		**If you are not having periods, is it due to:** ☐ Menopause ☐ Hysterectomy ☐ Pregnancy
Was this period normal?	☐ Yes ☐ No	
Number of days between first day of each period? _______		If menopausal, age or year of reaching menopause: _______
Number of days period lasts: _______		Comments: ______________________________

Chart #	Name	DOB

Are you having any of the following:

Heavy flow or passing blood clots?	☐ Yes ☐ No	Fluid retention/cravings/bloating before periods?	☐ Yes ☐ No
Recent change in period from usual pattern?	☐ Yes ☐ No	Irritability/mood swings/crying before periods?	☐ Yes ☐ No
Bleeding between periods?	☐ Yes ☐ No	Hot flashes/night sweats/insomnia?	☐ Yes ☐ No
Increase or change in vaginal discharge, odor, or itching/discomfort?	☐ Yes ☐ No	Vaginal dryness?	☐ Yes ☐ No

Comments:____

____

		Current form of birth control:	
Are you currently sexually active?	☐ Yes ☐ No		
Have you ever had sex?	☐ Yes ☐ No	☐ birth control pills ☐ condoms ☐ diaphragm ☐ IUD ☐ other: ____________ ☐ Depo Provera ☐ Ortho Evra patch ☐ Nuva Ring	☐ rhythm/natural family planning ☐ permanent sterilization ____ vasectomy ____ tubal ligation ____ hysterectomy ☐ none
Number of sexual partners in the past year: ______			
Number of lifetime sexual partners: ______			
Sexual partners are: ☐ Men ☐ Women ☐ Both			

Comments:____

____

Have you ever had an abnormal Pap smear?	☐ Yes ☐ No	If yes, when? __________ What were the results? ________	Was this followed up by colposcopy, LEEP, or other procedure? ☐ Yes ☐ No

Please check all that apply:

Monogomous (exclusive) sexual relationship	☐	Have been sexually mistreated	☐
Use barriers (i.e. condoms) for the prevention of STI's	☐	Pain or bleeding with intercourse	☐
Sexual activity comfortable and fulfilling	☐	Do not use barriers (i.e. condoms) for prevention of STI's	☐
		Sexual desire diminished or problems achieving orgasm	☐

Comments:____

____

OBSTETRICAL HISTORY

Total # of pregnancies ____	# of term (> 37 weeks) ____	# of preterm (< 37 weeks) ____	# of miscarriages ____	# of terminated pregnancies ____	# of living children ____

M/D/Y	Weeks	Vaginal/C-section	Weight	Sex	Place of Delivery	Complications (i.e. preterm labor, preeclampsia, gestational diabetes)

Chart #	Name	DOB

CURRENT MEDICATIONS

List your prescribed drugs and over the counter drugs, including vitamins and herbs

Name of Drug	Strength (Dose)	Frequency Taken (i.e. daily, twice daily)

ALLERGIES **Latex** ☐

Name of drug, food or substance	Age or date of reaction	Reaction you had

PAST & CURRENT HEALTH CONDITIONS		**HOSPITALIZATIONS OR SURGERIES & REASONS**	
AGE OR DATE		DATE	

FAMILY HISTORY

BE SURE TO INCLUDE CANCERS, DIABETES, THYROID DISORDERS, AND CARDIOVASCULAR DISEASE

	AGE		SIGNIFICANT HEALTH PROBLEMS		AGE		SIGNIFICANT HEALTH PROBLEMS
Father				**Children**	☐ M ☐ F		
Mother					☐ M ☐ F		
Sibling	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F			**Grandmother** *Maternal*			
	☐ M ☐ F			**Grandfather** *Maternal*			
	☐ M ☐ F			**Grandmother** *Paternal*			
	☐ M ☐ F			**Grandfather** *Paternal*			

Chart #	Name	DOB

HEALTH HABITS AND PERSONAL SAFETY					
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?	☐	Yes	☐	No
	If yes, are you on a physician prescribed medical diet?	☐	Yes	☐	No
	# of meals you eat in an average day?				
	# of servings in a typical day: Fruits & Vegetables _____ Meat, Poultry, Fish, Beans, Eggs & Nuts _____ Dairy _____ Carbohydrates _____				
	# of caffeinated beverages/day?				
Alcohol	Do you drink alcohol?	☐	Yes	☐	No
	If yes, what kind? / How many drinks (please circle) per day, per week, per month? _______				
	Have you ever felt you should cut down your drinking?	☐	Yes	☐	No
	Have people annoyed you by criticising your drinking?	☐	Yes	☐	No
	Have you ever felt bad or guilty about your drinking?	☐	Yes	☐	No
	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye- opener)?	☐	Yes	☐	No
Tobacco	Do you use tobacco?	☐	Yes	☐	No
	☐ Cigarettes – packs/day				
	☐ # of years / ☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?	☐	Yes	☐	No
Safety	Do you wear a seat belt or helmet when applicable?	☐	Yes	☐	No
	Do you wear sunscreen or skin protection when out in the sun?	☐	Yes	☐	No
	Do you live where you feel safe?	☐	Yes	☐	No
	If you have any guns or weapons in the household, are they locked up?	☐	Yes	☐	No

REVIEW OF SYSTEMS

Please circle symptoms you currently have:

Constitutional	Fatigue, malaise, fever, chills, weight gain, weight loss	**Musculoskeletal**	Muscle weakness, muscle or joint pain
Skin	Rash, sores, dry skin, mole changes or growth	**Gastrointestinal**	Frequent diarrhea, blood in stool, nausea/vomiting/indigestion, constipation, involuntary loss of gas or stool
HEENT	Double vision, seeing spots, other vision changes, earaches, ringing in ears, hearing problems, sinus problems, sore throat, mouth sores, dental problems, enlarged lymph nodes	**Genitourinary**	Blood in urine, pain with urination, strong urgency to urinate, frequent urination, incomplete emptying, involuntary/unintended urine loss, urine loss with coughing or lifting
Respiratory	Shortness of breath, painful breathing, spitting up blood, wheezing, chronic cough	**Neurological**	Frequent headaches or migraines, dizziness, seizure, trouble walking, memory problems, fainting
Cardiovascular	Chest pain or pressure, swelling of feet or ankles, irregular or rapid heartbeat, difficulty breathing on exertion	**Hematologic**	Easy bruising or bleeding
Breasts	Concerning lump(s), breast pain, nipple discharge, skin color changes, dimpling of skin, enlarged axillary lymph nodes	**Endocrine**	Heat or cold intolerances, hair loss, abnormal thirst
Psychological	Depressed symptoms, increased anxiety, mood swings, irritability		