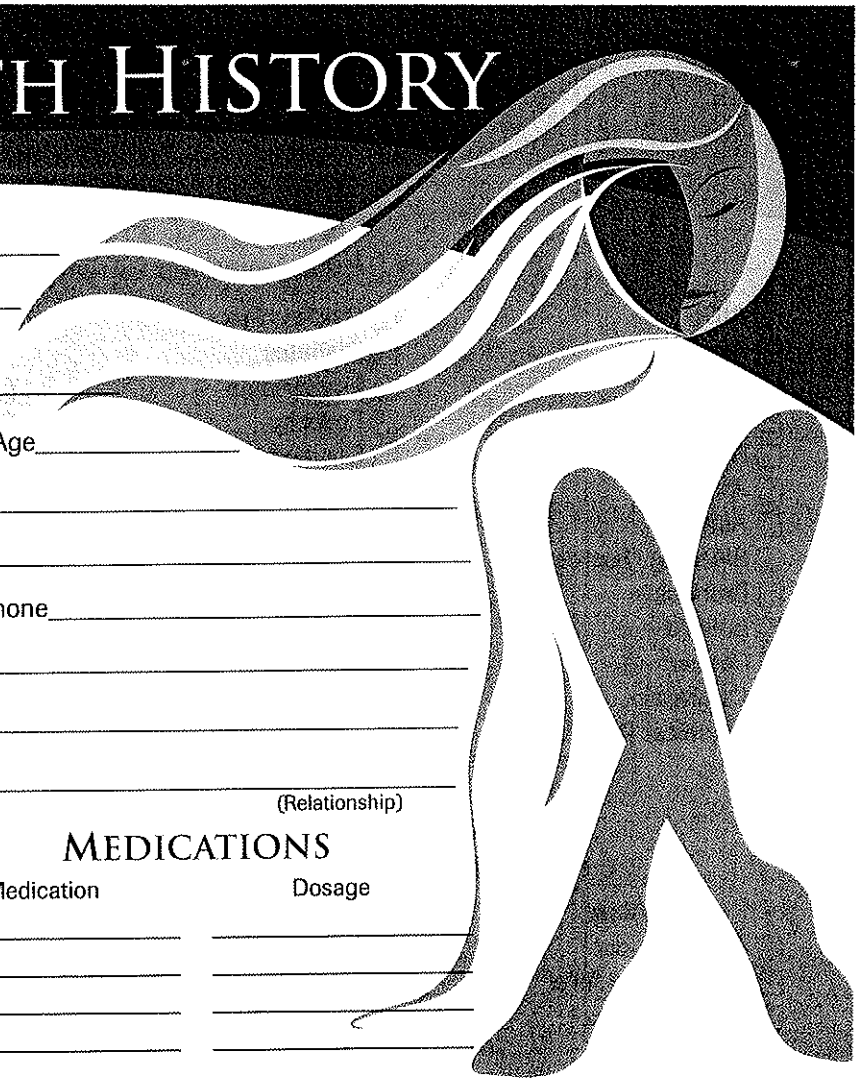
Women's Health History



Date_____

ID#_____

Name_____

Date of Birth_____ Age_____

Address_____

Address_____

Phone_____ Alternate Phone_____

E-mail address_____

Previous Physician _____

Emergency Contact_____
(Name and phone) (Relationship)

Allergies

Substance	Reaction

Medications

Medication	Dosage

Gynecological Health

General

Date of last Pap smear_____

Have you ever had an abnormal Pap smear? ☐ Yes ☐ No

Date of last mammogram_____

☐ Normal Results ☐ Abnormal Results

Do you do breast self-exams every month? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

Menstrual History

Age you were when periods started_____

Have you gone through menopause? ☐ Yes ☐ No

Are your periods regular? ☐ Yes ☐ No ☐ Varies

Cycle:_____ days (from start to start)

How many days do your periods last?_____

Flow: ☐ Light ☐ Medium ☐ Heavy

Do you have bleeding or spotting between your periods?

☐ Yes ☐ No

Describe the intensity of pain you experience with your periods:

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Incapacitating

Birth Control

Have you ever taken birth control pills?

☐ Yes ☐ No

If yes, when and for how long?_____

Other form(s) of birth control you have used:_____

_____

_____

Pregnancy History

Have you ever been pregnant? ☐ Yes ☐ No

If yes, how many times have you been pregnant?_____

How many children do you have? _____

Did you breast-feed? ☐ Yes ☐ No

Have any of your children died?

☐ Yes How many?_____ ☐ No

Were any of your children premature? ☐ Yes ☐ No

Have you ever had a miscarriage, stillborn child, or abortion?

☐ Yes (Please circle which) ☐ No

How old were you when you had your first child?_____

Do you have infertility problems? ☐ Yes ☐ No

If yes, please describe_____

_____

_____

_____

General Health Conditions

Check ☑ symptoms you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Lactose Intolerance
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers

Family History

Have any of your relatives or your husband's relatives had any of the following conditions? If so, please check ☑ and state which relative(s) have/had the condition.

Condition	Relative(s)
☐ Arthritis, gout	
☐ Asthma, hay fever	
☐ Cancer, Breast	
☐ Cancer, Colon	
☐ Cancer, Lung	
☐ Cancer, Ovarian	
☐ Cancer, Other	
☐ Chemical dependency	
☐ Cystic Fibrosis	
☐ DES exposure	
☐ Diabetes	
☐ Down's Syndrome	
☐ Heart disease, strokes	
☐ High blood pressure	
☐ Kidney Disease	
☐ Muscular Dystrophy	
☐ Osteoporosis	
☐ Spina Bifida	
☐ Tuberculosis	
☐ Other	

Lifestyle

Check ☑ information that applies to your current and last year's experiences.

- ☐ Alcohol use_____ Drinks per week_____
- ☐ Caffeine use_____ Cups per day_____
- ☐ Street drug use_____ Type_____
- ☐ Tobacco use_____ Packs per day_____
- ☐ Unusual stress_____
- ☐ Heavy lifting_____
- ☐ Chemical exposure_____
- ☐ Other_____

Do you take calcium supplements? ☐ Yes ☐ No

What is your level of exercise? ☐ Good ☐ Fair ☐ Poor

Describe_____

Hospitalizations

Year_____ Hospital_____

Reason for hospitalization and outcome:

Year_____ Hospital_____

Reason for hospitalization and outcome:

Year_____ Hospital_____

Reason for hospitalization and outcome:

Have you ever had a blood transfusion?

☐ Yes ☐ No

If yes, give approximate date_____

SYMPTOMS/CONDITIONS

Check ☑ symptoms you currently have or have had in the past year.

GYNECOLOGICAL

- ☐ Breast lump
- ☐ Decreased libido
- ☐ Hot flashes
- ☐ Increased vaginal discharge
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Unpleasant vaginal odor
- ☐ Vaginal infections
- ☐ Vaginal itching or burning

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Lack of bladder control

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

EXAM
(For office use only)

GENERAL

General appearance_____

_____

Height _____

Weight_____

Blood pressure_____

Temp_____

Pulse_____

Respiration_____

Eyes, Ears_____

Nose, Throat_____

Heart _____

Lungs _____

Abdomen_____

Back_____

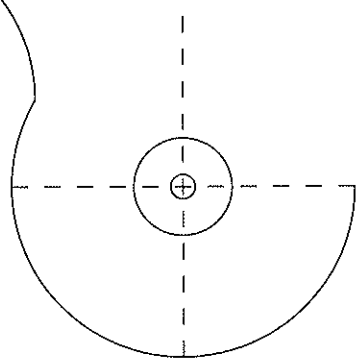
Urine _____

Blood_____

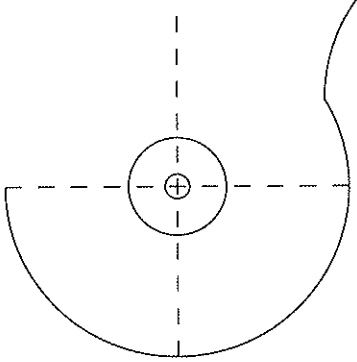
Other Labs_____

_____

Right ☐ Normal



Left ☐ Normal



R_____

L_____

BREAST EXAM

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PELVIC EXAM

Vulva_____

Bladder and Urethra_____

Vulvo-Vaginal Glands_____

Introitus_____

Perineum_____

Vagina_____

Cervix_____

Uterus_____

Adnexa: R_____ L_____

Cul-de-sac_____

Rectal_____

Assessment_____

_____

_____

_____

Plan _____

_____

_____

Physician's Signature_____ Date_____