Health History Form

Name: ____ DOB: ____________________

Women's Wellness Center requests this information for the purpose of providing patient care. No persons outside of Women's Wellness Center are provided with this information without a signed release of records.

Reason for today's visit: ______________________________________

Primary Care Provider: ______________________ Pharmacy: __________________

Please list the dates of your most recent: Flu Shot: ________ Pap Smear:_________ Pneumonia: __________

Mammogram: __________ Colonoscopy: __________ Bone Density: _________ Tdap (tetanus): __________

Please list your medications, including over the counter:

Medication	Dose	Frequency

Please list all allergies, including food allergies:

Medication/Food	Reaction

Gynecological History

At what age did your periods start? _________ First day of your last period: __________________

How many days do your periods last? ____________

Cycle: _________ days (from 1st day of last period to 1st day of next period)

Are your periods regular? □ Yes □ No □ Varies

If postmenopausal, have you had any bleeding since menopause? □ Yes □ No

If postmenopausal, age at menopause: ________

During your periods, do(did) you bleed lightly, moderately, or heavily? _____________

Describe the intensity of pain you experience with your periods: □ None □ Mild □ Moderate □ Severe

Do you experience pain with intercourse? □ Yes □ No

Are you currently using birth control? □ Yes □ No

If yes please specify: __________________________

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

Were you on birth control at the time of conception?

Have you ever had any of the following? (please check yes or no, if yes include date)

Abnormal Pap	□ Yes ________	□ No	HPV	□ Yes ________	□ No	Endometriosis	□ Yes ________	□ No
Gonorrhea	□ Yes ________	□ No	Gardasil	□ Yes ________	□ No	Infertility	□ Yes ________	□ No
Chlamydia	□ Yes ________	□ No	Fibroids	□ Yes ________	□ No	Ovarian Cysts	□ Yes ________	□ No

Other, please specify: ____

Obstetric History

How many times have you been pregnant? ____________________ □ Never

How many of your children were born full term? _______________ □ None

Were any of your children premature? □ Yes □ No If so, how many? ___________

Have you ever had a miscarriage, stillborn child, or abortion? □ Yes □ No If so, how many? ___________

Have any of your children passed away? □ Yes □ No

Past Pregnancies

Date of Delivery	# of Fetuses	Gestational Age	Gender	Baby's Weight	Type of Delivery	Length of Labor	Labor Epidural	Place of Delivery	Problems/Complications

Personal and Family Medical History

Maternal = Mother's side   Paternal = Father's side

MGM = maternal grandmother   MGF = maternal grandfather   PGM = paternal grandmother   PGF = paternal grandfather

	Self	Mom	Dad	Sister	Brother	MGM	MGF	PGM	PGF	other	Specify if other
Diabetes Type I	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Diabetes Type II	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Blood Clot in Legs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Blood Clot in Lungs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Heart Attack	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Lupus	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Varicose Veins	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Endometriosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Birth Defects	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Multiple Gestation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Anesthesia Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Kidney Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Frequent UTIs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Liver Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Hepatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
HIV/AIDS	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Neurologic Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Seizures/Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Migraines	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Lung Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Digestive problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Cancer:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Breast	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Ovarian	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Uterine	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Cervical	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Colon	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Liver Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Thyroid	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Lung	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Social History

Do you currently smoke cigarettes? □ Yes □ No If yes, number per day _______

Have you ever smoked? □ Yes □ No If yes, number of years_______

Current occupation and employer: ____

□ Part time □ Full time

Highest level of education: _____________________________

Are you: □ Single □ Married □ Divorced □ Widowed

Do you drink alcohol? □ Yes □ No

If yes, number of drinks per week ________

How many days in the past year have you had heavy drinking consumption? (4+ drinks) ________

Do you use street drugs? □ Yes □ No

Are you currently sexually active? □ Yes □ No

Have you ever been sexually active? □ Yes □ No

If yes please circle: Men Women Both

Do you use protection with intercourse? □ Yes □ No

Number of sexual partners in the past year __________ Number of sexual partners in lifetime _________

Do you use your seatbelt? □ Yes □ No

Any personal history of abuse? (please circle) □ Yes □ No

physical mental sexual

Do you feel safe in your home? □ Yes □ No

Do you have guns present in your home? □ Yes □ No

Do you drink caffeine? □ Yes □ No If so, how much? _____________

Is your exercise level: □ none □ occasional □ moderate □ heavy

Is your general stress level: □ low □ medium □ high

Do you follow a special diet? □ Yes □ No

If so, please explain ____

In the event of an emergency, do you accept a blood transfusion? □ Yes □ No

Are you adopted ? □ Yes □ No

Surgical History

Please list all surgeries and hospitalizations (other than c-sections previously listed):

Date	Surgery/Reason for Hospitalization	Doctor	Hospital	Problems/Complications

Do you have any implants, such as artificial heart valves or hip prosthesis? □ Yes □ No

Have you ever been told to use antibiotics prior to surgery because of a heart condition? □ Yes □ No

Symptoms/Conditions

Please check what symptoms you currently have or have had in the past year.

General
- ☐ Fatigue
- ☐ Recurrent fever
- ☐ Weight Gain _______ pounds
- ☐ Weight Loss _______ pounds

Skin
- ☐ Changes in moles
- ☐ Rashes

Ear, Nose, Mouth, and Throat
- ☐ Hearing loss
- ☐ Earache
- ☐ Sinus problems
- ☐ Recurrent sore throat
- ☐ Snoring
- ☐ Dry mouth
- ☐ Mouth ulcer

Respiratory
- ☐ Shortness of breath
- ☐ Persistent Cough
- ☐ Sputum
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ High blood pressure

Gastrointestinal
- ☐ Heartburn
- ☐ Difficulty swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Bowel changes
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal bleeding

Genito-Urinary
- ☐ Blood in the urine
- ☐ Abnormal bleeding
- ☐ Flank pain
- ☐ Trouble urinating
- ☐ Lack of bladder control
- ☐ Rash
- ☐ Lesion
- ☐ Vaginal discharge
- ☐ Vaginal odor
- ☐ Vaginal itching/irritation

Endocrine
- ☐ Irritability
- ☐ Tension
- ☐ Anxiety
- ☐ Depression
- ☐ Breast pain/tenderness
- ☐ Bloating
- ☐ Overwhelmed feeling
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Vaginal dryness
- ☐ Impaired memory
- ☐ Impaired concentration
- ☐ Decreased libido
- ☐ Orgasmic dysfunction
- ☐ Pain with intercourse

Muscoskeletal
- ☐ Muscle aches
- ☐ Muscle weakness
- ☐ Joint pain
- ☐ Back pain

Neurological
- ☐ Headaches
- ☐ Dizzyness
- ☐ Loss of consciousness
- ☐ Weakness
- ☐ Numbness
- ☐ Seizures

Psychological
- ☐ Depression
- ☐ Alcoholism
- ☐ Sleep disturbances

Lymphatic
- ☐ Swollen glands
- ☐ Bruise easily

Immunolgoic
- ☐ Runny nose
- ☐ Itching
- ☐ Hives
- ☐ Frequent sneezing

☐ NONE

Signature: ____ Date: ____________________

Interpreter Signature: ____ Date: ____________________

This page is for pregnant patients only

Genetics Screening

This includes the patient, baby's father, and anyone in either family.

Patient age 35 or older	□ Yes	□ No
Thalassemia (Italian, Greek, Mediterranean, or Asian background)	□ Yes	□ No
Neural tube defect (meningomyelocele, spina bifida, or anencephaly)	□ Yes	□ No
Congenital heart defect	□ Yes	□ No
Down Syndrome	□ Yes	□ No
Tay-Sachs (eg: Jewish, Cajun, French Canadian)	□ Yes	□ No
Canavan disease	□ Yes	□ No
Sickle Cell Disease or trait (African)	□ Yes	□ No
Hemophilia	□ Yes	□ No
Muscular Dystrophy	□ Yes	□ No
Cystic Fibrosis	□ Yes	□ No
Huntington's Chorea	□ Yes	□ No
Mental Retardation/Autism	□ Yes	□ No
if yes, was person tested for Fragile X?	□ Yes	□ No
Other inherited genetic or chromosomal disorder	□ Yes	□ No
Maternal Metabolic Disorder (eg, Type 1 Diabetes, PKU)	□ Yes	□ No
Patient or baby's father had a child with birth defects not listed above	□ Yes	□ No
Spontaneous miscarriage or stillbirth	□ Yes	□ No
Have you used medication/street drugs/alcohol since last period?	□ Yes	□ No
if yes, please list ____		
Any other genetic histories	□ Yes	□ No
if yes, please list ____		

Infection History:

This includes only the patient

Do you live with someone with TB or have you been exposed to TB?	□ Yes	□ No
Do you or your partner have a history of genital herpes?	□ Yes	□ No
Have you had a rash or viral illness since your last menstrual period?	□ Yes	□ No
Do you have a history of sexually transmitted diseases?	□ Yes	□ No
Do you have any reason to believe you are at high risk for HIV?	□ Yes	□ No
Do you have any reason to believe you are at high risk for Hepatitis B?	□ Yes	□ No
Have you been immunized against Hepatitis B?	□ Yes	□ No
Do you have a history of Pelvic Inflammatory Disease (PID)?	□ Yes	□ No
Do you have a history of infections of your tubes or ovaries?	□ Yes	□ No

Have you had any problems with this pregnancy (bleeding, cramping, headaches, visual problems, vaginal discharge, etc)?

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