

WOMEN'S HEALTH HISTORY FORM

NAME _____ **DATE OF BIRTH** _____

This questionnaire is confidential. The information is necessary to aid in your health care. If you have any questions, please ask the provider or nurse.

FAMILY HISTORY			
Have any of your immediate relatives - mother, father, sisters, brothers, grandparents (indicate maternal or paternal) had any of the following conditions?			
Yes	No	FAMILY HISTORY	Relationship
		Breast Cancer	
		Cervical Cancer	
		Diabetes	
		Heart Disease	
		Cholesterol/Lipid Disorder	
		High Blood Pressure	
		Ovarian Cancer	
		Thrombophlebitis/Blood Clots	
Yes	No	YOUR SURGICAL HISTORY	
		Breast Surgery	
		Gynecologic Surgery	
Yes	No	YOUR MEDICAL HISTORY	
Have <u>you</u> had any of the following conditions?			
		Thrombophlebitis (Blood Clots)	
		Polycystic Ovary Syndrome (PCOS)	
		Thyroid Disease	
		Migraine Headache	
		Depression	
		Eating Disorder	
		Acne (Severe)	
		Endometriosis	
		Pelvic Inflammatory Disease (PID)	
		Urinary Tract Infections	
		Human Papillomavirus Infection (HPV)	
		Herpes Simplex (Cold Sores)	
		Gonococci Infections Acute Gonorrhea	
		Chlamydia Infections	
		Syphilis	
		HIV-1 Infection	
		History of Vaginitis (Yeast, Bacterial)	
		Diabetes Mellitus	
		Heart Disease	
		High Blood Pressure	
		Other History	
Yes	No	SOCIAL HISTORY	
		Alcohol Use	
		Drug Use	
		Married Divorced Single <i>(Please circle)</i>	
		Physical Abuse	
		Psychological Abuse	
		Do you do monthly self breast exams?	
		Tobacco Use	

Yes	No	GYN SCREENING HISTORY	
		Is this your first Pap?	
		Last Pap Smear Date: _____	
		History of Abnormal Pap	
		Last Mammogram Date: _____	
Yes	No	OB HISTORY (Pregnancy)	
		Have you ever been pregnant? #	
		Abortions # _____	Miscarriage # _____
		Living Children # _____	Vaginal Deliveries # _____
		Cesarean Sections # _____	
MENSTRUAL HISTORY			
Yes	No	Age when periods began _____	
		Menses Regular	
		Menses Duration Normal	
		Cramps - Light Mod Heavy <i>(Please circle)</i>	
		Flow - Light Mod Heavy <i>(Please circle)</i>	
		Bleeding between periods	
		Do you think you are pregnant?	
		Vaginal Discharge	
		Vaginal Itch/Burning	
SEXUAL HISTORY			
Yes	No	Age of first intercourse _____ Never _____	
		Currently Sexually Active	
		Are your past or present sexual partners: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both	
		Monogamous Relationship (one exclusive partner)	
		Pain during Intercourse	
		Bleeding after Intercourse	
		Using Condoms	
		Would you like to start birth control?	
CURRENT BIRTH CONTROL METHOD <i>(Please circle)</i>			
		Condoms	Patch
		Diaphragm	Rhythm Method
		IM Inj. (Depo Provera)	Spermicides
		IUD	Implant (Implanon)
		Nuva Ring	Tubal Ligation
		Oral Contraceptives	Vasectomy
		Are you satisfied with your current birth control?	
Yes	No	CALCIUM INTAKE	
		Do you get 3 servings a day of dairy products? (8 oz milk, yogurt, 1½ oz cheese)	
		Do you take calcium supplements?	
Yes	No	HPV (GARDASIL) VACCINE	
		Have you received the HPV(Gardasil) vaccine?	
		If yes, how many doses?	