

Affix Label Here

Client's Name: _____

DOB: _____ Date: _____

Female Comprehensive History

Reason for today's visit: _____ Age: _____			
Some of these questions are personal, but they help us in evaluating your health.			
Yes, in the past	Yes, currently	No	
ALLERGIES			HOSPITALIZATIONS / SURGERIES
1. Are you allergic to: <input type="checkbox"/> latex <input type="checkbox"/> medication (please list) _____			Year Reason
GENERAL			FAMILY HISTORY
2. Have you been under a provider's care for any illness or chronic condition? If yes, describe: _____			Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know my family history.
3. Are you taking any medications (drugs, vitamins, over the counter medication, and herbal medication)? If yes, please list: _____ ♥			Has your parent, sibling or grandparent had any of the following?
			Yes No Diagnosis Relative
			<input type="checkbox"/> Cancer (Breast, Ovarian, Uterine, Colon)
			<input type="checkbox"/> Diabetes
			<input type="checkbox"/> Genetic Problems
			<input type="checkbox"/> High Blood Pressure
			<input type="checkbox"/> High Cholesterol or Fats
			<input type="checkbox"/> History of Blood Clotting Disorders
			<input type="checkbox"/> Other: _____
IMMUNIZATIONS ♥			<input type="checkbox"/> Father or brother with heart attack/stroke before age 55
4. Hepatitis B <input type="checkbox"/> shot 1 <input type="checkbox"/> shot 2 <input type="checkbox"/> shot 3			<input type="checkbox"/> Mother or sister with heart attack/stroke before age 65
5. HPV <input type="checkbox"/> shot 1 <input type="checkbox"/> shot 2 <input type="checkbox"/> shot 3			
6. Rubella/MMR			
7. Chicken Pox (<input type="checkbox"/> Disease / <input type="checkbox"/> Vaccine)			
CARDIOVASCULAR			SOCIAL HISTORY ♥
8. High Blood Pressure ♥			Yes No
9. High Cholesterol / Triglycerides			Nicotine, Alcohol, and/or Drug Use
10. Heart Disease/Murmur/Mitral Valve Problems ♥			Smoke cigarettes, cigars, pipes, or chew tobacco How much per day? _____
NEUROLOGIC			Drink alcohol (beer, wine, liquor) -- _____ drinks per week
11. Stroke ♥			Do you or your partner use street or IV drugs?
12. Migraine *			Do you feel like you should cut down or stop using alcohol/drugs?
13. Seizures/Epilepsy ♥			
GASTROINTESTINAL			Exercise
14. Irritable Bowel Syndrome or Crohn's Disease			Exercise _____ times per week for _____ minutes
15. Liver Disease / Jaundice / Hepatitis			Relationship & Safety
16. Gall Bladder Disease			<i>Violence and sexual abuse are common in many people's lives. There is help for you if you are being hurt or abused. (Note: PPM is required to report cases of child abuse or neglect that occurred as a minor, even if you are now over age 18.)</i>
ENDOCRINE ♥			My partner has threatened or frightened me.
17. Diabetes			<input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Declin
18. Thyroid Problems			My partner has physically abused me.
RESPIRATORY ♥			<input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Declin
19. Asthma / Tuberculosis / Chronic Cough			I have been forced to have sex.
GENITOURINARY			<input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Decline
20. Uterine Abnormality / Fibroids ♥			
21. Endometriosis ♥			
22. Pelvic Infection/Pain/PID ♥			
23. Breast Discharge / Lump			
MUSCULOSKELETAL			Please continue with form on back of this page. →
24. Broken Bones / Osteoporosis			*** Staff Use Only ***
MENTAL HEALTH ♥			HCA COMMENTS
25. In Counseling			_____
26. Depression / Anxiety / Bi-Polar			_____
27. Suicide Attempt			_____
28. Eating Disorder			_____
HEMATOLOGIC ♥			_____ <input type="checkbox"/> Hx Reviewed
29. Anemia			HCA Signature: _____ Date: _____
30. Blood Clotting Disorder (Leg / Lung / Brain)			* Give client headache questionnaire.
31. Sickle Cell Anemia / Trait / Thalassemia			

