

INITIAL HISTORY - COMPREHENSIVE

Date ____ / ____ / ____

Age: ____

Date of last menstrual period: ____ / ____ / ____

YES	NO	GENERAL (HPI)	YES	NO	SOCIAL HISTORY (continued)
		Is your health generally good?			Problems in living arrangements?
		Unexplained weight loss or gain or more than 10lbs in the past year?			Problems in school?
		Night sweats/hot flashes?			Do you have parental problems?
		Cancer? If yes, where/when?			Are you physically abused?
		Are you being treated for any illness/condition now? If yes, what?			Has anyone forced you to have sex?
		Do you take any folic acid supplements?			Are you sexually abused?
		Birth defects or genetic problems?			Are you afraid of your partner?
		Eye problems?			Are you afraid of a family member?
		Hearing problems?			Who helps and supports you with your problems? <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Sibling <input type="checkbox"/> Friend <input type="checkbox"/> Partner <input type="checkbox"/> Other: _____
		Frequent nosebleeds?			Have you ever used street drugs? If yes, what/when?
		Frequent sore throat?			_____
YES	NO	CARDIO-RESPIRATORY (HPI)	YES	NO	ENDOCRINE (HPI)
		Mitral valve prolapse?			Thyroid problems
		Heart murmur?			Diabetes
		Varicose veins?			Lupus
		Blood clots (head/leg/lungs)?			Have you received blood or blood products prior to 1978?
		Stroke or stroke-like problems?			Were any of your partners a street drug users?
		High blood pressure?			Were any of your partners a Hemophiliac?
		High cholesterol?			Were any of your partners infected with HIV/AIDS?
		Chronic cough or other breathing problems / asthma?			Were any of your partners MSM (men having sex with men)?
		Tuberculosis or exposure to tuberculosis?			
		Heart attack/Heart disease?	YES	NO	HEMATOLOGICAL/LYMPHATIC (HPI)
YES	NO	GASTROINTESTINAL (HPI)			Anemia (low iron)
		Stomach or bowel problems?			Sickle cell disease / trait
		Liver problems? (Hepatitis or tumor, etc)?			Bleeding clotting disorder
		Gallbladder problems?			Received blood products
		GERD/Hiatal Hernia/Ulcer?			HIV/AIDS
YES	NO	GENITOURINARY (HPI)	YES	NO	PAST IMMUNIZATION (HPI)
		Bladder, urine leaks, or kidney problems?			Hepatitis A? If yes: <input type="checkbox"/> complete <input type="checkbox"/> incomplete?
		Breast lump or nipple discharge?			Hepatitis B? If yes: <input type="checkbox"/> complete <input type="checkbox"/> incomplete?
		Vaginal discharge that itches, burns or has a bad odor?			HPV? If yes: <input type="checkbox"/> complete <input type="checkbox"/> incomplete?
		Pain with sex? Other sex problems?			Flu
		Coitus?			Flu, Seasonal
		History of sexually transmitted infection? If yes, what?			H1N1
YES	NO	MUSCULOSKELETAL (HPI)			MMR
		Arthritis?			Varicella (chicken pox)
		Osteoporosis?	YES	NO	STI/HIV RISKS (HPI)
		Other?			I have sex with: <input type="checkbox"/> men <input type="checkbox"/> women
YES	NO	SKIN (HPI)			In the past year I have had sex with ____ people.
		Acne or other skin problems?			In my lifetime I have had sex with ____ people.
		Tattoo?			I have <input type="checkbox"/> vaginal sex <input type="checkbox"/> oral sex <input type="checkbox"/> anal sex
		Piercing?	YES	NO	CONTRACEPTIVE HISTORY (HPI)
YES	NO	NEUROLOGICAL (HPI)			Current birth control method? _____
		Migraine Headaches?			Problem with method? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Aura (diagnosed by MD/NP/PA)			If yes, what? _____
		Numbness in arms/legs? (recurring?)			Method requested today? _____
		Seizures or epilepsy?			Total number of children desired? _____
YES	NO	SOCIAL HISTORY (HPI)			Planning a pregnancy in the next year? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Depression requiring treatment?	YES	NO	MENSTRUAL HISTORY (HPI)
		Have you ever considered suicide?			Age at menarche (first period)? _____
		Other psychological problems?			Number of pads/tampons used on heaviest day is _____
		Anxiety?			Length of period in days: _____
		Eating disorders - anorexia, bulimia?			Number of days between periods: _____
		Relationship problems?			Menstrual cycles are: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular
		Death of family member?			Do you experience, before or with periods: <input type="checkbox"/> nothing <input type="checkbox"/> cramps
		Death of friend?			<input type="checkbox"/> bloating <input type="checkbox"/> bowel problems <input type="checkbox"/> emotional changes <input type="checkbox"/> fatigue
					Do you experience post-coital bleeding? <input type="checkbox"/> Yes <input type="checkbox"/> No

INITIAL HISTORY - COMPREHENSIVE

MENSTRUAL HISTORY (continued) (HPI)		OB HISTORY (OB History)	
		Do you experience bleeding between your periods? <input type="checkbox"/> Yes <input type="checkbox"/> No	GRAVIDA Total number of pregnancies: _____
		Do you consider your periods heavy? <input type="checkbox"/> Yes <input type="checkbox"/> No	PARITY # Full term: _____ # Premature: _____
		Any recent changes in your period? <input type="checkbox"/> Yes <input type="checkbox"/> No	# Miscarriages: _____ # Elective Abortions: _____
YES NO TOBACCO / ALCOLHOL / DRUG (HPI)		Pregnancy #1	
		Do you smoke tobacco?	<input type="checkbox"/> normal spontaneous vaginal delivery <input type="checkbox"/> primary cesarean
		If yes, how much? _____ per day, for _____ years	<input type="checkbox"/> repeat cesarean <input type="checkbox"/> vaginal birth after cesarean
		Do you drink alcohol? If yes, how often?	birth weight: _____ lbs _____ oz
		<input type="checkbox"/> < 1 drink a month <input type="checkbox"/> 1-2 drinks a month <input type="checkbox"/> 3-5 drinks a week <input type="checkbox"/> 6+ drinks a week <input type="checkbox"/> socially only	<input type="checkbox"/> spontaneous abortion <input type="checkbox"/> elective termination of pregnancy
		Do you use drugs? If yes, what type?	<input type="checkbox"/> dilation and curettage <input type="checkbox"/> ectopic pregnancy
		How often? _____	Pregnancy #2
YES NO CURRENT MEDICATIONS (Current Medications)		Pregnancy #3	
		Are you currently taking any over-the-counter or prescription medication? If yes, what?	<input type="checkbox"/> normal spontaneous vaginal delivery <input type="checkbox"/> primary cesarean
			<input type="checkbox"/> repeat cesarean <input type="checkbox"/> vaginal birth after cesarean
			birth weight: _____ lbs _____ oz
			<input type="checkbox"/> spontaneous abortion <input type="checkbox"/> elective termination of pregnancy
			<input type="checkbox"/> dilation and curettage <input type="checkbox"/> ectopic pregnancy
YES NO ALLERGY (Allergies)		Pregnancy #4	
		Are you allergic to any drug, medication, latex or other substance, including local anesthesia? Is yes, to what?	<input type="checkbox"/> normal spontaneous vaginal delivery <input type="checkbox"/> primary cesarean
			<input type="checkbox"/> repeat cesarean <input type="checkbox"/> vaginal birth after cesarean
		Type of reaction: _____	birth weight: _____ lbs _____ oz
			<input type="checkbox"/> spontaneous abortion <input type="checkbox"/> elective termination of pregnancy
			<input type="checkbox"/> dilation and curettage <input type="checkbox"/> ectopic pregnancy
SURGICAL/HOSPITALIZATION (Surg/Hosp)			
		Year	Reason
FAMILY HISTORY (Family History)			
		Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Have your biological family (parents, brothers, sisters) had any of the following?	
		Yes No Diagnosis	Relative
			Osteoporosis?
			Diabetes?
			Heart disease/heart attack/stroke before age 50?
			High blood cholesterol?
			Genetic problems?
			Cancer? What kind? _____
			Blood clots?
			Other?
YES NO GYN HISTORY (GYN History with *)		Pregnancy #5	
		Do you have a past history of: <input type="checkbox"/> fibroids <input type="checkbox"/> endometriosis <input type="checkbox"/> adenomyosis <input type="checkbox"/> uterine anomaly <input type="checkbox"/> ovarian cysts <input type="checkbox"/> DES exposure	<input type="checkbox"/> normal spontaneous vaginal delivery <input type="checkbox"/> primary cesarean
		Do you have a history of abnormal pap smears? If yes, when? _____	<input type="checkbox"/> repeat cesarean <input type="checkbox"/> vaginal birth after cesarean
		What was the result? _____	birth weight: _____ lbs _____ oz
			<input type="checkbox"/> spontaneous abortion <input type="checkbox"/> elective termination of pregnancy
			<input type="checkbox"/> dilation and curettage <input type="checkbox"/> ectopic pregnancy
YES NO GYN HISTORY (GYN History with *)		Pregnancy #6	
		Do you have a past history of: <input type="checkbox"/> fibroids <input type="checkbox"/> endometriosis <input type="checkbox"/> adenomyosis <input type="checkbox"/> uterine anomaly <input type="checkbox"/> ovarian cysts <input type="checkbox"/> DES exposure	<input type="checkbox"/> normal spontaneous vaginal delivery <input type="checkbox"/> primary cesarean
		Do you have a history of abnormal pap smears? If yes, when? _____	<input type="checkbox"/> repeat cesarean <input type="checkbox"/> vaginal birth after cesarean
		What was the result? _____	birth weight: _____ lbs _____ oz
			<input type="checkbox"/> spontaneous abortion <input type="checkbox"/> elective termination of pregnancy
			<input type="checkbox"/> dilation and curettage <input type="checkbox"/> ectopic pregnancy
YES NO GYN HISTORY (GYN History with *)		Pregnancy #7	
		Do you have a past history of: <input type="checkbox"/> fibroids <input type="checkbox"/> endometriosis <input type="checkbox"/> adenomyosis <input type="checkbox"/> uterine anomaly <input type="checkbox"/> ovarian cysts <input type="checkbox"/> DES exposure	<input type="checkbox"/> normal spontaneous vaginal delivery <input type="checkbox"/> primary cesarean
		Do you have a history of abnormal pap smears? If yes, when? _____	<input type="checkbox"/> repeat cesarean <input type="checkbox"/> vaginal birth after cesarean
		What was the result? _____	birth weight: _____ lbs _____ oz
			<input type="checkbox"/> spontaneous abortion <input type="checkbox"/> elective termination of pregnancy
			<input type="checkbox"/> dilation and curettage <input type="checkbox"/> ectopic pregnancy

To the best of my knowledge the information I have provided is correct and complete. (HPI > Miscellaneous)

Client Signature / Date

Staff Signature / Date

History reviewed:

Staff Signature / Date

Staff Signature / Date