

MEDICAL HISTORY – FEMALES

Name _____

Date of Birth _____ Age _____ Today's Date _____

	YES	NO	
1	<input type="checkbox"/>	<input type="checkbox"/>	Adopted. Birth family history unknown. Go to next section.
2	<input type="checkbox"/>	<input type="checkbox"/>	If born before 1971, did your mother take DES while she was pregnant?
LIST only blood-related Mother(M), Father (F), Sister (S), Brother (B) who have had any of the following:			
	YES	NO	WHO
3	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol _____
4	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____
5	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure _____
6	<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____
7	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Disease Before age 50 _____
8	<input type="checkbox"/>	<input type="checkbox"/>	Stroke _____
9	<input type="checkbox"/>	<input type="checkbox"/>	Genetic Problems _____
10	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis _____
11	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots _____
12			Other: _____

A. REVIEW OF SYSTEMS

13 **Allergies** (medications, metals, latex, or anesthesia) None

List: _____

14 **Medications** currently taking (include herbs/vitamins) None

List: _____

15 **Vaccinations** Check if you have had the following vaccines:

- Tetanus Varicella (chicken pox)
- Diphtheria Pneumococcal
- Hepatitis A Meningococcal
- Measles/Mumps/Rubella Other: _____
- MMR _____
- Hepatitis B: 1st dose 2nd dose 3rd dose
- Vaccine for HPV (Gardasil®): 1st dose 2nd dose 3rd dose

Have you had or do you now have: (Please check)

	YES	NO	
General/Constitutional			
16	<input type="checkbox"/>	<input type="checkbox"/>	My health is generally good
17	<input type="checkbox"/>	<input type="checkbox"/>	Recent weight gain/loss (>10lbs) in the past year
18	<input type="checkbox"/>	<input type="checkbox"/>	Nights sweats/Hot flashes
19	<input type="checkbox"/>	<input type="checkbox"/>	Cancer: If yes, where/when: _____
20	<input type="checkbox"/>	<input type="checkbox"/>	Genetic condition or Birth defect
21	<input type="checkbox"/>	<input type="checkbox"/>	Eye problems (except glasses or contacts)
22	<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems
23	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nosebleeds
24	<input type="checkbox"/>	<input type="checkbox"/>	Frequent sore throat
Cardio-Respiratory			
25	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse
26	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur
27	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins
28	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots (head/leg/lungs)
29	<input type="checkbox"/>	<input type="checkbox"/>	Stroke or stroke-like problems
30	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
31	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol
32	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough or other breathing problems/asthma
33	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis(TB) or exposure to TB
Gastrointestinal			
34	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or bowel problems
35	<input type="checkbox"/>	<input type="checkbox"/>	Liver problems (hepatitis or tumor, etc.)
36	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder problems

AFFIX LABEL HERE

Client's Name: _____

DOB: _____ Patient # _____

A.(CONT'D) REVIEW OF SYSTEMS

	YES	NO	
Genitourinary			
37	<input type="checkbox"/>	<input type="checkbox"/>	Bladder, urine leaks or kidney problems
38	<input type="checkbox"/>	<input type="checkbox"/>	Uterine fibroids
39	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian cysts
40	<input type="checkbox"/>	<input type="checkbox"/>	Breast lump or nipple discharge
41	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal vaginal discharge/itch/odor
42	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis
43	<input type="checkbox"/>	<input type="checkbox"/>	Pain or bleeding with sex
Musculoskeletal			
44	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
45	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
46	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
Skin			
47	<input type="checkbox"/>	<input type="checkbox"/>	Acne
48	<input type="checkbox"/>	<input type="checkbox"/>	Tattoo
49	<input type="checkbox"/>	<input type="checkbox"/>	Piercing
50	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
Neurologic			
51	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches/Aura (diagnosed by clinician)
52	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy
53	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in arms/legs (recurring)
Psychological			
54	<input type="checkbox"/>	<input type="checkbox"/>	Depression (serious/prolonged)
55	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever considered suicide
56	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
Endocrine			
57	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems
58	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
Hematologic/Lymphatic			
59	<input type="checkbox"/>	<input type="checkbox"/>	Anemia (Low iron)
60	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease/trait
61	<input type="checkbox"/>	<input type="checkbox"/>	Blood clotting disorder

B. HOSPITALIZATION AND SURGERIES: LIST YEAR/REASON None

C. ACCIDENTS AND INJURIES: LIST YEAR/REASONS None

STAFF NOTES:

