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Health Centers Also in: Coldwater • Hillsdale • Sturgis • Three Rivers

Chart#: _____

FEMALE MEDICAL HISTORY FORM

PERSONAL INFORMATION (Please Print)

Date of Birth ____/____/____ Age _____ Social Security No. _____ Today's Date: ____/____/____

Name _____

GENERAL HEALTH

Reason for your visit today: _____

Medical care in the past year: _____ Medical Doctor: _____

Current medication (including herbals): _____

Date of Last Pap Smear (month/year): ____/____ Results: _____ **Is this your first pelvic exam?** Yes No

List all hospitalizations/injuries/surgeries (specify) _____

Allergies (including metals & Latex) _____

Did your mother take DES or other hormones to prevent miscarriage when pregnant with you? Yes No Unknown

Have you received the Gardasil vaccine? Yes No Are you vaccinated against Hepatitis B? Yes No

IF YOU DON'T KNOW YOUR FAMILY HISTORY BECAUSE YOU ARE ADOPTED, YOU DO NOT NEED TO ANSWER QUESTIONS 1-7

FAMILY HISTORY

Have your parents, brothers or sisters ever had:	Yes	No	Who?
1. Heart attack before 50			
2. High blood pressure			
3. Breast cancer			
4. Diabetes			
5. High cholesterol			
6. Uterine cancer			
7. Ovarian cancer			
8. Colon cancer			

SOCIAL HISTORY

Because so many women and girls are hurt by domestic violence, we ask everyone the following questions:

With whom do you live? _____

Within the past year, have you been hit, slapped, kicked, punched, shoved or otherwise physically hurt by anyone? Yes No

Has anyone ever forced you to have sex? Yes No

Have you ever been forced into sex by your current partner? Yes No

Are you afraid of your partner or anyone in your life? Yes No

Do you feel unsafe or threatened in your life right now? Yes No

Do you smoke? No Yes # of cigarettes a day _____

How much alcohol do you drink per week? _____

Do you use street drugs? No Yes If yes please list _____

SEXUAL HISTORY

Age at time of first intercourse? _____

Are you currently in a sexual relationship now? Yes No

Do you have sex with men, women or both? (circle one)

Do you have Vaginal Anal Oral sex? (check all that apply)

Do you use condoms or dental dams with each sex act? Yes No

Are you currently using birth control? Yes No Method _____

Total number of sex partners in your lifetime? _____

Do you think you may be pregnant now? Yes No

Have you had sex without using pregnancy protection since your last period? Yes No

The following practices put you at risk for AIDS & Hepatitis: multiple partners, IV drug use, intercourse with an IV drug user, anal intercourse, hemophilia, blood transfusion before 1984

Do you consider yourself at risk? Yes No

Have you had a new sex partner in the past 6 months? Yes No

PREGNANCY HISTORY

Total number of times pregnant: _____ Never

When did your last pregnancy end _____ age at first pregnancy _____

Are you currently breast feeding? Yes No

Number of live births: _____

Number of stillbirths _____ Number of miscarriages _____

Number of abortions _____

Types of deliveries: Vaginal Caesarean Premature

Complications with pregnancies, i.e. toxemia, genetic problems, diabetes Yes No

If yes, please explain _____

Have you ever had an ectopic (tubal) pregnancy? Yes No

Are you planning future pregnancies? Yes No

MEDICAL HISTORY FORM

NAME _____ CLIENT/CHART# _____

Do you now have, or have you ever had any of the following problems (check all that apply):

	YES	NO	PAST		YES	NO	PAST
SKIN				Complete the following regarding your menstrual cycle: Age periods began: _____ First day of your last menstrual period (date) _____ How often do you have a period? Every ___ days How many days do you bleed? ____ Average number of pads/tampons per day? _____ Menstrual discomforts/cramps? Unusual or missed periods in the past year? Spotting or bleeding between periods?			
Acne							
Rash							
Cancer							
EYES, EARS, NOSE & THROAT							
Are you hearing or sight impaired?							
Wear contacts/glasses?							
Wear hearing aids?							
CARDIAC							
Murmurs?							
Chest pain?							
Heart surgery?							
High blood pressure?							
Stroke							
Blood clots							
RESPIRATORY							
Asthma							
Bronchitis							
Pneumonia							
TB							
Cough							
Sputum							
GASTRO-INTESTINAL							
GERD?							
Hepatitis?							
Gall bladder?							
Liver disease?							
Stomach disease?							
Bowel disease?							
GYNECOLOGICAL							
Frequent vaginal infections?							
Abnormal PAP?							
PID?							
Unusual discharge/odor?							
Vaginal itching/burning/sores?							
Genital warts?							
Herpes?							
VD/Gonorrhea/Chlamydia/Syphilis?							
Uterine growths/fibroids/abnormality?							
Do you douche?							
Pain/bleeding with intercourse?							
				URINARY			
				Kidney/bladder problems/infections?			
				Pain with urination?			
				ENDOCRINE			
				Thyroid?			
				Diabetes?			
				MUSCULOSKELETAL			
				Joint pain?			
				Scoliosis?			
				BREASTS			
				Implants?			
				Lumps?			
				Cysts?			
				Mass?			
				Discharge?			
				Surgery?			
				Cancer?			
				HEMATOLOGY			
				Anemia?			
				Bleeding disorder?			
				Hemophilia?			
				Sickle Cell?			
				NEUROLOGIC			
				Severe headaches?			
				Diagnosed migraines?			
				Seizures?			
				Fainting?			
				Numbness/tingling?			
				PSYCHOLOGICAL/EMOTIONAL			
				Depression?			
				Bipolar?			
				Schizophrenia?			
				Suicidal?			
				Anxiety?			

To the best of my knowledge, the above information is complete and accurate.

Signature of Client _____ Date _____

Staff Signature: _____ Date _____