



**Comprehensive Female History**

Date \_\_\_\_\_

**Review of Systems**

Do you have any of the following **NOW**?

- 1. General**
- Yes No**
- Recent weight gain or loss (20 lbs)
- Night sweats/hot flashes
- 2. Cardiovascular**
- Chest pain
- 3. Respiratory**
- Chronic cough
- Shortness of breath
- Other trouble breathing
- 4. Neurologic**
- Headaches
- Numbness in arms or legs
- 5. Gastrointestinal**
- Nausea or vomiting
- Abdominal pain
- Diarrhea
- 6. Musculoskeletal**
- Leg pain
- 7. Eyes**
- Double vision
- 8. Lymphatic**
- Swollen lymph nodes
- 9. Breasts**
- Lump in breast
- Nipple discharge
- Breast tenderness
- 10. Genitourinary**
- Frequent urination
- Burning with urination
- Vaginal discharge/ itching
- Vaginal sores/blisters/ bumps
- Problems with your periods
- Do you think you might be pregnant?
- Do you have problems with sex?
- 11. Skin**
- Rash
- 12. Other Problems**

List \_\_\_\_\_

**Immunization/Shot History**

Have **YOU HAD** your shots?

- Yes No Unsure
- Measles/ Rubella shot (usually get by age 5)
- Tetanus vaccine (shot) in the last 10 years
- Hepatitis B shots (a series of 3 shots)
- Gardasil (HPV) shots (a series of 3 shots)

**Your Family History**

13.  Yes  No Are you adopted?
14. Check any that **parents, brothers or sisters** had:
- Diabetes
- Cancer
- High cholesterol
- Blood clotting disorders
15.  Yes  No Has your father or brother had heart disease or stroke before he was 55 years old?
16.  Yes  No Has your mother or sister had heart disease or stroke before she was 65 years old?
17.  Yes  No Did your mother take DES while she was pregnant with you?

For Staff use

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Reviewed by Clinician** \_\_\_\_\_ **Date** \_\_\_\_\_

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**For Staff use**  
History Changes:  None  As noted  
Notes:

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Reviewed by Clinician** \_\_\_\_\_ **Date** \_\_\_\_\_

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History Changes:  None  As noted  
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