

FEMALE HISTORY FORM

Date: ___/___/___

NAME _____

Patient ID# _____

D.O.B. _____

Age _____

A. REVIEW OF SYSTEMS: Please check any that apply	
YES	NO
GENERAL	
	1. Is your health generally good?
	2. Unexplained weight loss or gain of more than 10 lbs. in the past year?
	3. Night sweats / hot flashes?
	4. Cancer? If yes, where / when?
	5. Tobacco use? If yes, for how many years? _____ If yes, <input type="checkbox"/> smoking? How many/day? <input type="checkbox"/> chewing tobacco?
	6. Alcohol use? If yes, how many drinks/week?
	7. Are you being treated for any illness/condition now? If yes what?
	8. Do you currently take medicine: prescription, over-the-counter, or herbal? If yes, what? Do you take any folic acid supplements?
	9. Birth defects or genetic problems?
	10. Eye problems (except glasses or contacts)?
	11. Hearing problems?
	12. Frequent nosebleeds?
	13. Frequent sore throat?
CARDIO-RESPIRATORY	
	14. Mitral valve prolapse?
	15. Heart murmur?
	16. Varicose veins?
	17. Blood clots (head / leg / lungs)?
	18. Stroke or stroke-like problems?
	19. High blood pressure?
	20. High cholesterol?
	21. Chronic cough or other breathing problems / asthma?
	22. Tuberculosis or exposure to tuberculosis?
GASTROINTESTINAL	
	23. Stomach or bowel problems?
	24. Liver problems (hepatitis or tumor, etc.)?
	25. Gallbladder problems?
GENITOURINARY	
	26. Urine leakage or bladder or kidney problems?
	27. Uterine fibroids?
	28. Ovarian cysts?
	29. Breast lump or nipple discharge?
	30. Vaginal discharge that itches, burns or has a bad odor?
	31. Endometriosis?
	32. Pain with sex? Other sex problems/libido?
	33. Previous abnormal pap? When?
	34. Did your mother take DES when she was pregnant with you?
	35. Age of first vaginal intercourse _____
	36. History of sexually transmitted infection? Check type: <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> HPV/Genital warts <input type="checkbox"/> Herpes <input type="checkbox"/> Syphilis <input type="checkbox"/> PID <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Trich
MUSCULOSKELETAL	
	37. <input type="checkbox"/> Arthritis? <input type="checkbox"/> Osteoporosis? <input type="checkbox"/> Other? _____
SKIN	
	38. <input type="checkbox"/> Acne or other skin problems? If yes, what? _____ <input type="checkbox"/> Tattoo? <input type="checkbox"/> Piercing? If yes, where? _____
NEUROLOGICAL	
	39. Migraine headaches / Aura (diagnosed by MD / NP / PA)?
	40. Seizures / epilepsy?
	41. Numbness in arms / legs (recurring)?
PSYCHOLOGICAL	
	42. Depression requiring treatment? Have you ever considered suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No Other psychological problems? Eating disorder or anxiety?

A. (cont'd) REVIEW OF SYSTEMS			
YES	NO		
ENDOCRINE			
	43. Thyroid problems?		
	44. Diabetes?		
	45. Adrenal failure/Steroid use (Addison's)		
HEMATOLOGICAL/LYMPHATIC			
	46. Anemia (Low Iron)?		
	47. Sickle cell disease / trait?		
	48. Blood clotting disorder?		
ALLERGY			
	49. Are you allergic to any drug, medication, latex or other substance, including local anesthesia? If yes, to what? Type of reaction: _____		
IMMUNIZATION (Check the ones you have received)			
50. <input type="checkbox"/> Diphtheria?	55. <input type="checkbox"/> Meningococcal?		
51. <input type="checkbox"/> Hepatitis A?	56. <input type="checkbox"/> Pneumococcal?		
52. Hepatitis B <input type="checkbox"/> shot 1? <input type="checkbox"/> shot 2? <input type="checkbox"/> shot 3?	57. <input type="checkbox"/> Tetanus?		
53. Human Papillomavirus (HPV) <input type="checkbox"/> shot 1? <input type="checkbox"/> shot 2? <input type="checkbox"/> shot 3?	58. <input type="checkbox"/> Varicella (chicken pox)?		
54. <input type="checkbox"/> Measles/Mumps/Rubella (MMR)?	59. Other _____		
B. HOSPITALIZATION AND SURGERIES			
Year	Reason		
C. ACCIDENTS AND INJURIES			
Year	Reason		
D. 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? If yes, please specify _____	
		Blood clots?	
		High blood pressure?	
ADDITIONAL STAFF COMMENTS / EXPLANATIONS (by number)			

PLEASE COMPLETE OTHER SIDE

NAME _____

Patient ID# _____ D.O.B. ____/____/____ Age ____

E. PREGNANCY HISTORY
 never pregnant currently breastfeeding

DELIVERED				ABORTION / MISCARRIAGE				
Mo.	Yr.	Vag.	C-Sec.	Birth Weight	Year	Weeks	Spont.	Induced

F. CONTRACEPTIVE HISTORY

Current birth control method? _____ How long used? _____

Any problems with this method? Yes No

If yes, what? _____

What method do you want to use now? _____

Total number of children desired? _____

Are you planning a pregnancy in the NEXT year? Yes No**WHICH OF THE FOLLOWING METHODS HAVE YOU USED IN THE PAST?**

METHOD	COMMENT/PROBLEM
<input type="checkbox"/> Abstinence	
<input type="checkbox"/> Tubal Ligation/Essure/Adiana	
<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Birth Control Pill; Brand: _____	
<input type="checkbox"/> Ortho Evra (The Patch)	
<input type="checkbox"/> Nuvaring (The Ring)	
<input type="checkbox"/> Implant: <input type="checkbox"/> Norplant <input type="checkbox"/> Implanon	
<input type="checkbox"/> Depo-Provera (The Shot)	
<input type="checkbox"/> IUD: Mirena or Paragard	
<input type="checkbox"/> Condoms	
<input type="checkbox"/> Diaphragm? <input type="checkbox"/> FemCap <input type="checkbox"/> Lea's Shield	
<input type="checkbox"/> Sponge/ Spermicide/ Film/ Foam	
<input type="checkbox"/> Rhythm Method or Natural Family Planning	
<input type="checkbox"/> Withdrawal	

G. SOCIAL HISTORYDo you exercise? wear your seatbelt? check your breasts? Emotional or Relationship problems?Problems in Living arrangements? School? Legal problems? Arrests? Divorce? Do you have any parental problems? Are you physically abused? Has anyone forced you to have sex? Are you or have you been sexually abused?

Are you afraid of your:

 Partner? Family member? Friend?*If you are under 18 we are required to report abuse to the proper authorities***H. MENSTRUAL HISTORY**

1. Age periods began? _____

2. Number of pads / tampons used on heaviest day? _____

3. Length of period? _____ (days) # of days between periods?

4. Are your periods usually regular? Yes No

5. Last period started on _____

It seemed Normal Not normal6. Do you experience, before or with periods, Cramps? Bloating? Bowel problems? Emotional changes/PMS?7. Do you have vaginal bleeding after sex? Yes No

8. Do you have vaginal bleeding between menstrual periods?

 Yes No**I. STI / HIV RISKS**

Number of sex partners in your life? MEN: ____ WOMEN: ____

How many sex partners have you had during the past year? _____

Does your partner have sex with men women both ?Do you have (check all that apply) vaginal oral anal sex ?**COMMENTS**

Have you ever used street drugs?

If yes, type _____ how often used _____ ?

Have you received blood or blood products prior to 1978? _____

Were any of your partners: a street drug user? a Hemophiliac? infected with HIV / AIDS? MSM (men having sex with men)?

Have you ever shared needles?

Examples: Injecting drugs, tattooing, piercing?

STAFF COMMENTS (do not write anything in this space)

Date of Last Annual exam: _____

Was a pap smear done? _____

Current Health Issues:

To the best of my knowledge the information I have provided is correct and complete.

Patient Signature: _____ Date: _____

Clinician Signature: _____ Date: _____