FEMALE MEDICAL HISTORY

Patient Name ______________________ Date ____________ Age ________

MRN ______________ Clinic Name ______________ Date of Birth ______________

ALLERGIES

Are you allergic to any drug or medication, including anesthesia? ❑ No ❑ Yes

Are you allergic to Latex? ❑ No ❑ Yes Are you allergic to iodine or shellfish? ❑ No ❑ Yes

If you answered yes to any of the above, please write the medication and type of reaction: ______________

MEDICATIONS

List all medications or drugs you are now taking or take often including prescription medications, over-the-counter medications, herbal medications, vitamins, minerals, or supplements: ______________

PAST MEDICAL HISTORY

Check if *you* have now or in the past have had: ❑ No past medical conditions

- ❑ Abnormal Pap
- ❑ Anemia
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Blood Transfusion
- ❑ Breast Cancer
- ❑ Lobular carcinoma-in-situ
- ❑ Atypical hyperplasia
- ❑ Chest radiation
- ❑ Cancer: Cervical
- ❑ Cancer: Ovarian
- ❑ Cancer: Uterine
- ❑ Cancer: Other ______________
- ❑ Stroke
- ❑ Chlamydia
- ❑ DVT/Blood Clot in Legs
- ❑ Depression
- ❑ DES Exposure
- ❑ Other Medical Conditions:
- ❑ Diabetes
- ❑ Drugs/Alcohol Abuse
- ❑ Eating Disorder
- ❑ Endometriosis
- ❑ Fibroid uterus
- ❑ Fracture
- ❑ Gallbladder Disease
- ❑ Genital Herpes
- ❑ Genital Warts
- ❑ Gonorrhea
- ❑ Heart Failure
- ❑ Hepatitis B
- ❑ HIV/AIDS
- ❑ Clotting Disorder
- ❑ High Cholesterol
- ❑ High Blood Pressure
- ❑ Infertility
- ❑ Inflammatory Bowel Disease
- ❑ Kidney Failure
- ❑ Liver Disease/Tumor
- ❑ Lupus
- ❑ Migraine
- ❑ Heart Attack
- ❑ Osteoporosis
- ❑ PID
- ❑ PCOS
- ❑ Psychiatric Disorder
- ❑ Pulmonary Embolus
- ❑ Seizure/Epilepsy
- ❑ Suicide Attempt
- ❑ Syphilis
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ UTI, recurrent
- ❑ Vaginitis, recurrent
- ❑ Heart Valve Disease

PAST SURGICAL HISTORY

Check if *you* have had any of these surgeries: ❑ Never had surgery

- ❑ Appendix removed
- ❑ Breast Surgery: ______________
- ❑ Tubal Ligation
- ❑ Cesarean Section
- ❑ Gallbladder removed
- ❑ D&C
- ❑ Surgery for Weight Loss
- ❑ Heart Surgery: ______________
- ❑ Hernia Repair
- ❑ Hysterectomy (Uterus removed)
- ❑ Liver Biopsy
- ❑ Uterus, tubes, ovaries removed
- ❑ Other surgery on uterus, tubes, or ovaries
- ❑ Other: ______________

DIAGNOSTIC TEST HISTORY

Have you ever had a pap test? ❑ Yes ❑ No When? ______________ Was it normal? ______________

Have you ever had a mammogram? ❑ Yes ❑ No When? ______________ Was it normal? ______________

FAMILY HISTORY

If you are ADOPTED and do not know your biological family's medical history, **SKIP this section.**

Check any of your BLOOD relatives (Parents, Brothers, Sisters, Children ONLY) who have had any of the following:

- ❑ Blood Disease who: ____________
- ❑ Heart Attack who: ____________
- ❑ Stroke who: ____________
- ❑ Cancer who: ____________
  Type: ____________
- ❑ Diabetes who: ____________
- ❑ High Cholesterol who: ____________
- ❑ High Blood Pressure who: ____________
- ❑ Osteoporosis who: ____________
- ❑ Renal Disease who: ____________

IMMUNIZATION HISTORY

Check the immunizations/vaccinations you've had:

- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ HPV
- ❑ MMR/Rubella
- ❑ Tetanus
- ❑ Varicella

CONTRACEPTIVE HISTORY

Birth control methods used in the past: ____________

List any problems with these birth control methods: ____________

MENSTRUAL HISTORY

❑ No menses yet ❑ Going through menopause now ❑ Post-menopausal: last period ___ years ago (skip to next section)

Age when periods started: _____ Periods come: ❑ less often than monthly ❑ monthly ❑ more often than monthly

Periods are: ❑ regular ❑ irregular (every month is different)

Periods last ____ days. Bleeding is ❑ light ❑ moderate ❑ heavy

PREGNANCY HISTORY

❑ Never been pregnant (skip to next section)

Number of: Births: _____ Miscarriages: _____ Abortions: _____ Ectopic/Tubal: _____ Living Children: _____ C-Sections: _____

Breastfeeding: ❑ Yes ❑ No Age at first pregnancy: ______ Age at last pregnancy: ______

List any problems with a pregnancy, birth, or abortion: ____________

____

SUBSTANCE USE

Have you ever used street, recreational, or IV drugs? ❑ Yes ❑ No If so, what? ____________

Do you currently use street, recreational, or IV drugs? ❑ Yes ❑ No If so, what? ____________

Do you smoke cigarettes? ❑ Yes ❑ No ❑ Not anymore If so, how many/how often? ____________

Do you use other types of tobacco? ❑ Yes ❑ No If so, how many/how often? ____________

Do you drink alcohol? ❑ Yes ❑ No If so, how often/how much? ____________

Do you feel you have a problem with drugs or alcohol? ❑ Yes ❑ No Why? ____________

SEXUAL HISTORY

❑ No Intercourse Yet

How many people have you had sex with in the last year? ____________

Have you had sex with someone new in the last 90 days? ❑ Yes ❑ No

Do you have sex with: ❑ Men ❑ Women ❑ Both

Does the person(s) you have sex with have sex with: ❑ Men ❑ Women ❑ Both ❑ Unknown

Does the person(s) you have sex with only have sex with you? ❑ Yes ❑ No ❑ Unknown

Is your sexual contact (check all that apply): ❑ Vaginal ❑ Oral ❑ Anal ❑ Other: ____________

Do you use condoms? ❑ Always ❑ Sometimes ❑ Never

Have you been exposed to a Sexually Transmitted Infection (STI) recently? ❑ No ❑ Yes: ____________

Has the person(s) you have sex with had any STI symptoms in the last 60 days? ❑ Yes ❑ No ❑ Unknown

Have you ever shared needles (tattoo, IV drug use, etc.)? ❑ No ❑ Yes: ____________

Have you had sex with someone who uses IV drugs? ❑ Yes ❑ No ❑ Unknown

Did you get a blood transfusion before 1985? ❑ No ❑ Yes

LIFESTYLE/CHALLENGES/SUPPORT

Any recent major life changes? ❑ Yes ❑ No If so, what? ____________________

Any concerns regarding weight or eating? ❑ Yes ❑ No If so, what? ____________________

Are you being abused sexually, physically, or emotionally? ❑ Yes ❑ No If so, how? ____________________

____

Are you being forced to do something against your will? ❑ Yes ❑ No If so, what? ____________________

Do you have a good support system? ❑ Yes ❑ No If so, who? ____________________

Do you eat a healthy diet? ❑ Yes ❑ No Do you exercise regularly? ❑ Yes ❑ No

Do you work? ❑ Yes ❑ No If yes: ❑ Full Time ❑ Part Time Are you a student? ❑ Yes ❑ No

REVIEW OF SYSTEMS

Check whether you are having any of these symptoms NOW, or VERY OFTEN:

Constitutional

❑ No ❑ Yes Weight gain (unexplained, more than 20 lbs. in the past year)
❑ No ❑ Yes Weight loss (unexplained, more than 20 lbs. in the past year)
❑ No ❑ Yes Fever/chills
❑ No ❑ Yes Hot Flashes
❑ No ❑ Yes Fatigue/lethargy/malaise

Cardio/Cerebrovascular

❑ No ❑ Yes Chest pain
❑ No ❑ Yes Palpitations/Irregular heart beat
❑ No ❑ Yes Syncope/fainting

Gastrointestinal

❑ No ❑ Yes Abdominal pain
❑ No ❑ Yes Constipation
❑ No ❑ Yes Diarrhea
❑ No ❑ Yes Nausea/Vomiting
❑ No ❑ Yes Rectal bleeding
❑ No ❑ Yes Bloody stool
❑ No ❑ Yes Involuntary loss of gas/stool

Genitourinary

❑ No ❑ Yes Painful urination/Dysuria
❑ No ❑ Yes Leaking urine/Incontinence
❑ No ❑ Yes Frequent urination
❑ No ❑ Yes Pain with intercourse or other sexual problems
❑ No ❑ Yes Abnormal vaginal bleeding
❑ No ❑ Yes Vaginal discharge
❑ No ❑ Yes Vulvo-vaginal itching
❑ No ❑ Yes Pelvic pain
❑ No ❑ Yes Bad cramps with periods
❑ No ❑ Yes Bleeding/spotting between periods
❑ No ❑ Yes Blood in urine
❑ No ❑ Yes Incomplete bladder emptying
❑ No ❑ Yes Urine loss when coughing/lifting
❑ No ❑ Yes PMS

Ears, Nose, Mouth, Throat

❑ No ❑ Yes Hearing problems
❑ No ❑ Yes Frequent nosebleeds
❑ No ❑ Yes Tooth/gum problems
❑ No ❑ Yes Frequent sore throat
❑ No ❑ Yes Ringing in the ears
❑ No ❑ Yes Earaches
❑ No ❑ Yes Sinus Problems
❑ No ❑ Yes Mouth Sores

Respiratory

❑ No ❑ Yes Chronic cough
❑ No ❑ Yes Shortness of breath
❑ No ❑ Yes Difficult breathing on exertion
❑ No ❑ Yes Painful breathing
❑ No ❑ Yes Wheezing
❑ No ❑ Yes Spitting up blood

Skin/Breast

❑ No ❑ Yes Rash
❑ No ❑ Yes Skin lesion
❑ No ❑ Yes Breast lump
❑ No ❑ Yes Breast pain
❑ No ❑ Yes Nipple discharge
❑ No ❑ Yes Dry skin
❑ No ❑ Yes Moles (growth/changes)

Endocrine

❑ No ❑ Yes Alopecia (hair loss)
❑ No ❑ Yes Cold or heat intolerance
❑ No ❑ Yes Excessive hunger, thirst, or urination

(Continued on next page...)

REVIEW OF SYSTEMS (CONTINUED)

Check whether you are having any of these symptoms NOW, or VERY OFTEN:

Neurologic

- ❑ No ❑ Yes Headache
- ❑ No ❑ Yes Visual disturbance
- ❑ No ❑ Yes Weakness
- ❑ No ❑ Yes Dizziness
- ❑ No ❑ Yes Seizures
- ❑ No ❑ Yes Numbness
- ❑ No ❑ Yes Migraine/Aura

Psychiatric

- ❑ No ❑ Yes Little interest or pleasure in doing things
- ❑ No ❑ Yes Feeling down, depressed, or hopeless
- ❑ No ❑ Yes Feeling suicidal
- ❑ No ❑ Yes Seeing a therapist or psychiatrist
- ❑ No ❑ Yes Anxiety

Eyes

- ❑ No ❑ Yes Problems seeing not corrected by glasses/contacts
- ❑ No ❑ Yes Eye burning, discharge, itching or pain
- ❑ No ❑ Yes Vision changes
- ❑ No ❑ Yes Glasses/Contacts

Allergic/Immunologic

- ❑ No ❑ Yes Hay fever
- ❑ No ❑ Yes Hives/urticaria
- ❑ No ❑ Yes Contact dermatitis

Musculoskeletal

- ❑ No ❑ Yes Back pain
- ❑ No ❑ Yes Myalgias (muscle aches)
- ❑ No ❑ Yes Muscle weakness

Hematologic/Lymphatic

- ❑ No ❑ Yes Easy bruising
- ❑ No ❑ Yes Easy bleeding
- ❑ No ❑ Yes Enlarged lymph nodes
- ❑ No ❑ Yes Cuts that do not stop bleeding

Patient Signature: ______________________________ **Date:** ______________