

## Comprehensive Healthcare for Women Patient Health History Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please tell us the reason for your visit today: \_\_\_\_\_

Gynecologic History	
First day of last normal menstrual period:	Number of days between periods (cycle length):
Number of days of flow (menstrual length):	Age periods began:
How would you describe your flow? (Check all that apply) <input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light <input type="checkbox"/> Other (explain)	
If you have heavy periods:	Number of tampons/pads used per hour:
	Do you pass blood clots? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have breakthrough bleeding between periods? <input type="checkbox"/> No <input type="checkbox"/> Yes	Do you have cramping or painful periods? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have any concerns regarding your periods? <input type="checkbox"/> No <input type="checkbox"/> Yes (explain)	
If you are postmenopausal, at what age did you go through menopause? <span style="float: right;">Have you had abnormal spotting?    <input type="checkbox"/> No    <input type="checkbox"/> Yes</span>	
Are you currently sexually active? <input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had sexual intercourse? <input type="checkbox"/> No <input type="checkbox"/> Yes
Number of sexual partners in the last year:	Sexual partners are: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both
Do you have any concerns regarding sexual intercourse? <input type="checkbox"/> No <input type="checkbox"/> Yes (explain)	
What is your current method of birth control?	
Date of last Pap smear:	Result of Pap smear:
Have you ever had an abnormal Pap smear? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, list dates and results, if known:
Date of last Mammogram: <input type="checkbox"/> Never had	Result of Mammogram:
Date of last Bone Density Test: <input type="checkbox"/> Never had	Result of Bone Density Test:
Date of last Colonoscopy: <input type="checkbox"/> Never had	Result of Colonoscopy:
Do you do breast self-examinations? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, how often?

Have you ever been diagnosed with any of the following?

HPV <input type="checkbox"/> No <input type="checkbox"/> Yes	Bacterial Vaginosis <input type="checkbox"/> No <input type="checkbox"/> Yes	Trichomoniasis <input type="checkbox"/> No <input type="checkbox"/> Yes
Gonorrhea <input type="checkbox"/> No <input type="checkbox"/> Yes	Chlamydia <input type="checkbox"/> No <input type="checkbox"/> Yes	Syphilis <input type="checkbox"/> No <input type="checkbox"/> Yes
Genital Warts <input type="checkbox"/> No <input type="checkbox"/> Yes	Genital Herpes <input type="checkbox"/> No <input type="checkbox"/> Yes	HIV/AIDS <input type="checkbox"/> No <input type="checkbox"/> Yes

Obstetric History		
Total number of pregnancies:	Number of full-term births:	Number of preterm births:
Number of miscarriages:	Number of abortions:	Number of living children:
Any ectopic pregnancies? <input type="checkbox"/> No <input type="checkbox"/> Yes		Any multiple births (twins, triplets, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes

Baby	Birth Date	Weeks Pregnant	Length of Labor	Type of Delivery (Vaginal, Cesarean, etc.)	Birth Weight	Gender	Detail of any complications
1							
2							
3							
4							

Medical History				
Please check all that apply.				
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Blood clots in lungs/legs	<input type="checkbox"/> Fibroids	<input type="checkbox"/> Migraines/headaches	<input type="checkbox"/> Breast cancer
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Infertility	<input type="checkbox"/> Alzheimer's disease	<input type="checkbox"/> Uterine cancer
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Asthma	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Ovarian cancer
<input type="checkbox"/> Congenital heart disease	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Recurrent miscarriages	<input type="checkbox"/> Depression	<input type="checkbox"/> Colon cancer
<input type="checkbox"/> Stroke	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Polycystic ovaries/PCOS	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Other cancer _____
<input type="checkbox"/> Anemia	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Seasonal allergies
<input type="checkbox"/> Bleeding tendencies	<input type="checkbox"/> Bowel problems	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Osteopenia/osteoporosis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Blood transfusions	<input type="checkbox"/> Irritable bowel syndrome	<input type="checkbox"/> Bladder problems	<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Other _____

**PLEASE COMPLETE BOTH SIDES OF THIS FORM**

Medications		
Include vitamins, nonprescription or over-the-counter medications, and herbal products.		
Drug/Dose/Frequency	Drug/Dose/Frequency	Drug/Dose/Frequency

Allergies		
List any medication or food allergies and reaction. <input type="checkbox"/> No known medication allergies		
Allergy/Reaction	Allergy/Reaction	Allergy/Reaction

Surgical History	
Type of Surgery/Year/Hospital	Type of Surgery/Year/Hospital

Family Medical History					
Medical Condition	Relative/Age of Onset	Medical Condition	Relative/Age of Onset	Medical Condition	Relative/Age of Onset
High blood pressure		Birth defects		Breast cancer	
High cholesterol		Multiple births		Uterine cancer	
Heart disease		Mental illness		Ovarian cancer	
Stroke		Depression		Colon cancer	
Diabetes (Type I or II?)		Alcoholism		Bladder cancer	
Thyroid disease		Alzheimer's disease		Prostate cancer	
Blood clot in lungs/legs		Osteoporosis		Other	

Social History			
Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Living with Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated			
Occupation:		Highest level of education completed:	
Do you smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, how many cigarettes per day?	How many years have you smoked?	
If you ever smoked, when did you quit?		If you smoke currently, do you want to quit? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, how often?	How many drinks at a time?	
Do you use street/recreational/narcotic drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, what and how often?	
Do you exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes	What type of exercise?	How long and how often?	
Do you drink caffeinated beverages? <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, what and how much per day?	
What is your daily intake of dairy products or calcium supplements?			
Do you wear a seatbelt when in a car? <input type="checkbox"/> No <input type="checkbox"/> Yes		Do you have an advance directive or living will? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have a history of domestic violence? <input type="checkbox"/> No <input type="checkbox"/> Yes      Physical abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes      Sexual abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes      Emotional abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes			

Review of Systems					
Please check all that apply.					
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Vision changes	<input type="checkbox"/> Rapid heartbeat	<input type="checkbox"/> Constipation	<input type="checkbox"/> Abnormal bleeding	<input type="checkbox"/> Breast pain
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Involuntary loss of gas/stool	<input type="checkbox"/> Premenstrual syndrome	<input type="checkbox"/> Breast lumps
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Cough	<input type="checkbox"/> Pain with urination	<input type="checkbox"/> Painful intercourse	<input type="checkbox"/> Memory problems
<input type="checkbox"/> Fever	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Urinary urgency	<input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Loss of height	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Bloody stool	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Frequent bruising
<input type="checkbox"/> Seeing spots	<input type="checkbox"/> Chest pain/pressure	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Involuntary loss of urine	<input type="checkbox"/> Rash	<input type="checkbox"/> Enlarged lymph nodes

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date reviewed by Provider with Patient

**PLEASE COMPLETE BOTH SIDES OF THIS FORM**