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) ☐ Heavy ☐ Medium ☐ Light ☐ Other (explain)	
If you have heavy periods:	Number of tampons/pads used per hour:
	Do you pass blood clots? ☐ No ☐ Yes
Do you have breakthrough bleeding between periods? ☐ No ☐ Yes	Do you have cramping or painful periods? ☐ No ☐ Yes
Do you have any concerns regarding your periods? ☐ No ☐ Yes (explain)	
If you are postmenopausal, at what age did you go through menopause?	Have you had abnormal spotting? ☐ No ☐ Yes
Are you currently sexually active? ☐ No ☐ Yes	Have you ever had sexual intercourse? ☐ No ☐ Yes
Number of sexual partners in the last year:	Sexual partners are: ☐ Men ☐ Women ☐ Both
Do you have any concerns regarding sexual intercourse? ☐ No ☐ 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? ☐ No ☐ Yes	If yes, list dates and results, if known:
Date of last Mammogram: ☐ Never had	Result of Mammogram:
Date of last Bone Density Test: ☐ Never had	Result of Bone Density Test:
Date of last Colonoscopy: ☐ Never had	Result of Colonoscopy:
Do you do breast self-examinations? ☐ No ☐ Yes	If yes, how often?

Have you ever been diagnosed with any of the following?

HPV ☐ No ☐ Yes	Bacterial Vaginosis ☐ No ☐ Yes	Trichomoniasis ☐ No ☐ Yes
Gonorrhea ☐ No ☐ Yes	Chlamydia ☐ No ☐ Yes	Syphilis ☐ No ☐ Yes
Genital Warts ☐ No ☐ Yes	Genital Herpes ☐ No ☐ Yes	HIV/AIDS ☐ No ☐ 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? ☐ No ☐ Yes	Any multiple births (twins, triplets, etc.)? ☐ No ☐ 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.

☐ High blood pressure	☐ Blood clots in lungs/legs	☐ Fibroids	☐ Migraines/headaches	☐ Breast cancer
☐ High cholesterol	☐ Diabetes	☐ Infertility	☐ Alzheimer's disease	☐ Uterine cancer
☐ Heart attack	☐ Asthma	☐ Endometriosis	☐ Seizures	☐ Ovarian cancer
☐ Congenital heart disease	☐ Lung disease	☐ Recurrent miscarriages	☐ Depression	☐ Colon cancer
☐ Stroke	☐ Hypothyroidism	☐ Polycystic ovaries/PCOS	☐ Anxiety	☐ Other cancer _____
☐ Anemia	☐ Liver disease	☐ Urinary incontinence	☐ Eating disorder	☐ Seasonal allergies
☐ Bleeding tendencies	☐ Bowel problems	☐ Kidney disease	☐ Osteopenia/osteoporosis	☐ Other _____
☐ Blood transfusions	☐ Irritable bowel syndrome	☐ Bladder problems	☐ Autoimmune disease	☐ 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. ☐ 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: ☐ Single ☐ Married ☐ Living with Partner ☐ Divorced ☐ Widowed ☐ Separated		
Occupation:		Highest level of education completed:
Do you smoke? ☐ No ☐ 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? ☐ No ☐ Yes
Do you drink alcohol? ☐ No ☐ Yes	If yes, how often?	How many drinks at a time?
Do you use street/recreational/narcotic drugs? ☐ No ☐ Yes		If yes, what and how often?
Do you exercise? ☐ No ☐ Yes	What type of exercise?	How long and how often?
Do you drink caffeinated beverages? ☐ No ☐ 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? ☐ No ☐ Yes		Do you have an advance directive or living will? ☐ No ☐ Yes
Do you have a history of domestic violence? ☐ No ☐ Yes	Physical abuse? ☐ No ☐ Yes	Sexual abuse? ☐ No ☐ Yes Emotional abuse? ☐ No ☐ Yes

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

Patient Signature

Provider Signature

Date reviewed by Provider with Patient

PLEASE COMPLETE BOTH SIDES OF THIS FORM