

WOMEN'S HEALTH CONSULTANTS, PA

HEALTH HISTORY

Name: _____

Date: _____

Birth Date: _____

Marital Status (optional): M S D W Live with mate _____

The following information is confidential and will not be released without your permission.

Personal health history. Have you now, or ever had, problems with the following? Check those that apply.

- | | |
|---|--|
| <input type="checkbox"/> Allergies
<input type="checkbox"/> Headaches, migraines
<input type="checkbox"/> Lung problems
<input type="checkbox"/> Heart disease
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Blood clots, bleeding disorder
<input type="checkbox"/> Blood transfusion
<input type="checkbox"/> Anemia, low blood
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Liver disease
<input type="checkbox"/> Bladder or kidney problems
<input type="checkbox"/> Gallbladder disease
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Injuries, describe _____
<input type="checkbox"/> Cancer, type _____
<input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Breast lumps, breast discharge
<input type="checkbox"/> Have had a mammogram, date _____
_____ normal _____ abnormal
<input type="checkbox"/> VD, if so, circle: Gonorrhea, Chlamydia, Herpes, Warts
<input type="checkbox"/> Pelvic infections
<input type="checkbox"/> Seizures
<input type="checkbox"/> Depression, emotional problems
<input type="checkbox"/> Chemical dependency: drug of choice _____
<input type="checkbox"/> Eating disorder
<input type="checkbox"/> Nervous condition, used medicine for nerves
<input type="checkbox"/> Physical or sexual abuse by another
<input type="checkbox"/> Have participated in counseling
<input type="checkbox"/> Have had recent weight change; how much? _____
<input type="checkbox"/> Have problems sleeping |
|---|--|

Please list any surgeries or hospitalizations you have had (other than childbirth).

Year	Number of days in hospital	Type of surgery or illness
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any medicines, prescriptions or over-the-counter drugs that you use (including aspirin, etc.)

Do you use caffeine? _____

If yes, how much? _____

Do you smoke? ____ Yes ____ Never ____ Have quit

If so, how much? _____

Number of years you smoked _____

When did you quit? _____

Have you used any recreational/street drugs? _____
 Please list: _____

Are you currently using? _____

Have you ever injected drugs? _____

How much alcohol do you consume in an average week? _____

What do you do for exercise? _____

Name: _____

Date: _____

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Sexual and Reproductive History

Age at first menstrual period: _____
 How many days are there from the first day of one period to the first day of the next period? _____
 How many days do you flow? _____
 Do you have pain or problems with your period? _____
 Describe _____
 Medicine used? _____
 Any bleeding between periods? _____
 Date of your last period _____
 Was it normal _____

What was the date of your last Pap smear? _____
 Have you ever had an abnormal Pap smear? _____
 If so, what year? _____
 Describe treatment _____

Have you ever had intercourse? _____
 Are you currently sexually active? _____
 Do you have sex with? ___ men ___ women ___ both
 In the past year I have had ___ (number) sex partners.
 Do you have concerns about sexual matters that you wish to discuss? _____

Are you now using a method of contraception? _____
 (including vasectomy, tubal ligation)
 Methods you are using _____
 Any problems with this? _____
 How long have you used this method? _____
 Is pregnancy desired? ___ yes ___ no ___ not at this time

What method of contraception have you used in the past?

Method	Length of Time	Problems
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list the number of times you have been pregnant: _____; premature births _____; miscarriages _____; abortions _____; ectopic pregnancies _____; living children _____.

Births Mo/Yr	Weight lbs/oz	Sex	Weeks Pregnant	Type of Delivery/Complications
____/____	____/____	_____	_____	_____
____/____	____/____	_____	_____	_____
____/____	____/____	_____	_____	_____
____/____	____/____	_____	_____	_____
____/____	____/____	_____	_____	_____
____/____	____/____	_____	_____	_____
____/____	____/____	_____	_____	_____

Family Medical History: Please check if any of your *blood* relatives have had:

- | | | |
|--|-------------------------------|----------------------------------|
| _____ Thyroid disease | _____ High Blood Pressure | _____ Heart Disease/Heart Attack |
| _____ Stroke | _____ Kidney or Liver Disease | _____ Chemical Dependency |
| _____ Cancer | _____ Diabetes | _____ Mental Illness |
| _____ Abuse by others in family | | |
| _____ Has there been a recent death or illness in your family? | | |