**Women's Health History**

1. **Reason for your visit.**
   - Re-check __________
   - Depo Injection __________
   - Pap smear __________
   - STD testing/exposure/symptoms __________
   - Birth Control __________
   - Other __________

2. **Pap Smear History:** First Pap □ Yes □ No, Date of last __________
   - Normal □ Abnormal
   - Ever had an abnormal pap □ No □ Yes

3. **Menstrual History:** Age of 1st menstrual period ________
   - Date of last menstrual period __________ □ Regular □ Irregular
   - Describe any changes in menstrual period __________________________
   - # of pregnancies ______ # of births ______
   - Pregnant now □ No □ Yes
   - Breast feeding □ No □ Yes

4. **Breast History:** Check all symptoms you are currently experiencing.
   - Breast discharge, color __________, □ Breast changes, ____________
   - Lump in breast □ Warm or tender breasts □ Other __________
   - Do you perform breast self-exams □ No □ Yes □ Monthly □ Occasionally

5. **Vaginal History:** Check all symptoms you are currently experiencing.
   - Discharge: color __________, □ How long __________ □ odor
   - Pain: Location __________ □ Bleeding □ itching
   - Burning with urination □ Burning, Other __________
   - Sores or lesions? __________
   - Have you had 3 HPV Vaccines □ No □ Yes

6. **Sexual History:**
   - Have you ever had sex? □ No □ Yes Age began? ________ Last sex ______
   - Number of partners? ________ Last 3 months? ________ Lifetime? ________
   - Sexual preference: □ Male □ Female □ Both
   - Site Preference: □ Oral □ Anal □ Vaginal
   - Birth control method/s? __________
   - Condom usage: □ Always □ Usually □ Sometimes □ Never
   - Have you ever had a sexually transmitted disease? □ No □ Yes ________

7. **Do you have any drug allergies?** □ No □ Yes List drug and reaction __________

8. **Do you have any food or other allergies?** □ No □ Yes List and describe the
   reaction __________

9. **Current Medications**
   - Name ________ Dosage ________ Reason Prescribed ________

10. **Physician prescribed diet** □ No □ Yes, type __________

11. **Caffeine use:** □ Never □ Yes, how much __________
    - □ 2/week □ > 2/month □ > 2/year
    - How long? ________
    - Type: □ Coffee □ Soda □ Energy drinks

12. **Tobacco Use:** □ Never □ Yes, complete information below.
    - □ Cigarettes □ Never □ < 1/2 pk/day □ > 1/2 pk/day
    - □ 1 pk/day □ < 1 pk/day □ > 1 pk/day How long? ________
    - □ Other: □ Type ________ □ Amt ________ □ How long? ________

13. **Alcohol Use:** □ Never □ Yes, how much __________
    - □ 2/week □ > 2/month □ > 2/year
    - How long? ________ Type: □ Beer □ Liquor □ Both

14. **Illegal drugs:** □ Never □ Yes, how much __________
    - □ 2/week □ > 2/month □ > 2/year
    - How long? ________ Type: __________

15. **Medical History** Circle any current medical problems you have. Record date or year of diagnosis.

   - Anemia
   - Scoliosis
   - Mental problems
   - Asthma
   - Epilepsy
   - Migraine Headaches
   - Bleeding disorder
   - Heart murmur
   - Physical limitations
   - Cancer
   - Heart problems
   - Rheumatic Fever
   - Cerebral Palsy
   - Hepatitis
   - Arthritis
   - Colitis
   - High blood pressure
   - Thyroid problems
   - Congenital Defect
   - Irritable Bowel
   - Tuberculosis
   - Cystic Fibrosis
   - Kidney stone
   - Diabetes
   - Congenital Heart Disease
   - Stroke

   Other: __________

16. **List any surgeries with dates:**

17. **List any recent hospitalizations, reason & date:**

18. **Family History:** **Complete if this is your first visit.** Has anyone in your immediate family (parents, siblings, grandparents) had a history of any of the following? List the family member next to the illness.

   - Thyroid problems __________
   - Alzheimer’s/Dementia __________
   - Anemia-Sickle cell __________
   - Asthma/Respiratory __________
   - Bleeding problems __________
   - Cancer __________
   - Diabetes __________
   - Tuberculosis __________
   - Heart Disease __________
   - High blood pressure __________
   - Mental/Emotional problems __________
   - Stroke __________

   Is your Mother living □ Yes □ No
   Is your Father living □ Yes □ No