WOMEN'S CENTER FOR HEALTH

INITIAL HEALTH HISTORY FORM

Today's Date _____

Legal Name:_____ Age: _____ Date of Birth: _____

Reason for your visit: _____

GENERAL MEDICAL HISTORY

	none	self	mother	father	sibling	your child	grand-parent	aunt or uncle
Alcoholism								
Arthritis/Lupus								
Asthma								
Blood disorder								
Cancer								
Diabetes								
Heart disease								
High blood pressure								
Stroke								
Kidney disease								
Liver disease								
Mental disorder								
Depression								
Seizure disorder								
Osteoporosis								
Thyroid disease								

Do you smoke/use tobacco? No Yes How many per day? _____

Do you drink alcohol? No Yes How many drinks per week? _____

Do you use recreational/illegal drugs? No Yes What and how long? _____

Have you had any surgery? List what surgeries you have had and the year you had it:

What was the month and year of your last physical exam? _____
What was the month and year of your last:

Pap test _____never / normal / abnormal If abnormal Pap, did you have a colposcopy? Y N

Bone density _____ never / normal / abnormal Cholesterol _____ never / normal / abnormal

Colonoscopy _____ never / normal / abnormal Mammogram _____ never / normal / abnormal

____ **No known drug allergies** ____ **Allergic to latex** ____ **Allergic to tapes/adhesives**

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____
(If you have more than two allergies to drugs, please attach a separate sheet listing them.)

_____
patient's name date of birth

What Medications do you take? (Include birth control / hormones)

Prescription Medication	Dose, # times/day	What is it for?

(If you take more than four prescription medications, please attach a separate sheet listing them.)

Do you take a multivitamin? YES NO Calcium supplement? YES NO Other _____

OB/GYNE MEDICAL HISTORY

How old were you when you had your first period? _____

How many days from the first day of one period to the first day of the next one? _____

How many days do your periods last? _____

Are your periods regular? YES NO Do you have cramps with your period? NO YES: mild moderate severe

Do you bleed or spot between periods? NO YES Do you bleed after intercourse? NO YES

What was the first day of your last period, or if you are menopausal, when was your last period? _____

Do you have any menopausal symptoms? NO YES What? _____

How old were you when you first had sexual intercourse? _____ # of sexual partners _____

Are you sexually active now? YES NO If yes, is your partner MALE FEMALE

Do you use anything to keep from getting pregnant? YES NO Are you trying to get pregnant? YES NO

If yes, what? (circle) Condoms DepoProvera Pill Patch Ring Tubal Ligation Vasectomy

IUD inserted (date & type of IUD) _____ Diaphragm Spermicides Rhythm Withdrawal

Do you have: (circle) FIBROIDS ENDOMETRIOSIS POLYCYSTIC OVARIES HIGH RISK HPV

Summary of pregnancies

_____ / _____ / _____ / _____ / _____

# of pregnancies / #deliveries >37 weeks / # deliveries < 37 weeks / # miscarriages or abortions / # living children

	delivery date	# weeks of pregnancy	vaginal?	c-sect.	baby's weight	diabetes?	high BP?	other complications	miscarried at ? weeks	aborted
1										
2										
3										
4										
5										

_____
reviewed by date