WOMEN'S CENTER FOR HEALTH

INITIAL HEALTH HISTORY FORM

	Today's Date								
Legal Name:	al Name:								
Reason for your visit:									
		GENER	AI ME	:טוכעו א	ISTORY				
GENERAL MEDICAL HISTORY									
	none	self mo	other	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									
Triyroid disease		<u> </u>							
Do you smoke/use tob	acco?	No	Yes	How n	nany per da	ay?			
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 surg	gery? List wh	nat surgeries ye	ou hav	e had and	the year y	ou had it:			
What was the month a What was the month a			al exan	n?					
Pap test	_never / nor	mal / abnorma	ıl Ifa	ibnormal f	Pap, did yo	u have a	colposcopy	/? Y N	
Bone density	_ never / nor	al Ch	Cholesterol		_ never / normal / abnormal				
Colonoscopy	never / normal / abnormal		al Ma	Mammogram		_ never / normal / abnormal			
No known dru	ug allergies	s Alle	ergic t	to latex		Allergic	to tapes/	adhesives	
Allergic to:		Reaction:							
Allergic to:	Reaction:								
(If you have more than tu	o allergies to	druge places o	ttach a	congrate	hoot licting t	hom)			

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

Prescription Medication	W	hat Medication	ons do you	take? (In	clude bir	th control / horr	•	's name	date of	birth	
(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 **Description** **Description*		Prescrip	tion Medica	ation		Dose, # times	/day		What is it for?		
Do you take a multivitamin? YES NO Calcium supplement? YES NO Other		•				,					
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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 se 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 vaginal? c-sect. baby's weight diabetes? high BP? other complications at 7 weeks abort one pregnancy other complications at 7 weeks abort one pregna	-		-	-		•	•				
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	1	,	pregnancy	Ŭ		, ,		0	complications	at ? weeks	
	2										
3	3										
4	4										
5	5										

date

reviewed by