FEMALE PERSONAL HISTORY

Do you have or ever had the following: ***(please check all that apply)***

A. REVIEW OF SYSTEMS:

YES	NO	GENERAL
		1. My health is generally good
		2. Unexplained weight loss or gain of more than 10 lbs
		3. Cancer - If yes, where/when?
		4. Are you being treated for any illness / condition now? If yes, what ______________________________

5. What medication are you currently taking? (please include over-the-counter, herbal or prescriptions)

YES	NO	EYES
		6. Eye problems (except glasses or contacts)
YES	**NO**	**EARS/NOSE/MOUTH/THROAT**
		7. Hearing problems
YES	**NO**	**CARDIOVASCULAR**
		8. Heart murmur
		9. Blood clots (head/leg/lungs)
		10. Stroke or stroke-like problems
		11. High blood pressure
		12. High cholesterol
YES	**NO**	**RESPIRATORY/UPPER BODY**
		13. Chronic cough or other breathing problem
		14. Asthma
		15. Tuberculosis or exposure to tuberculosis
		16. Breast lump or discharge
YES	**NO**	**GASTROINTESTINAL**
		17. Stomach or bowel problems
		18. Liver problems (hepatitis or tumor, etc.)
		19. Gallbladder problems
YES	**NO**	**GENITOURINARY**
		20. Bladder or kidney problems ❒ Burning urination ❒ Blood in urine
		21. Uterine fibroids
		22. Ovarian cysts
		23. Vaginal discharge that itches/burns or has a bad odor
		24. Endometriosis
		25. Vaginal bleeding after sex? ❒ N/A

26. Have you ever had an abnormal Pap Test? ☐Yes ☐No
Date: ______________________________
Result: ______________________ Colposcopy ❒Yes ❒ No
Treatment: ❒ Cryotherapy ❒ LEEP ❒ None
Follow-up Paps: ❒ Normal ❒ Abnormal ❒ None
❒ Other:______________________________

27. Had you had any of the following? ***(check all that apply)***

☐ Chlamydia ☐ Herpes
☐ Gonorrhea ☐ Syphilis
☐ Genital Warts (HPV) ☐ Trichomoniasis
☐ HIV ☐ Pelvic Inflammatory Disease (PID)
☐ Hepatits (A,B or C)

YES	NO	MUSCULOSKELETAL
		28. Arthritis or osteoporosis
YES	**NO**	**SKIN**
		29. Acne or other skin problems. Please Specify:
YES	**NO**	**ENDOCRINE**
		30. Thyroid problems
		31. Diabetes/diabetes during pregnancy
YES	**NO**	**PSYCHOLOGICAL**
		32. Depression
		33. Psychiatric illness

YES	NO	NEUROLOGICAL
		34. Diagnosed with frequent/severe headaches?

Do you ever experience any of the following before a headache:
☐ Double vision, blindness ☐ Flashing lights and wavy lines
☐ Numbness or weakness ☐ Speech problems

YES	NO	
		35. Seizures/epilepsy
		36. Numbness in arms/legs (recurring)
YES	**NO**	**HEMATOLOGICAL / LYMPHATIC**
		37. Anemia
		38. Blood clotting disorder
YES	**NO**	**ALLERGY / IMMUNOLOGY**
		39. Are you allergic to any drug, medication, latex or other substance? What: __________
		40. MMR Immunization
		41 Hepatitis B Immunization (all 3 shots)
		42. HPV Gardasil Immunization (all 3 shots)

B. HOSPITALIZATION AND SURGERIES

Year	Reason

C. OTHER SIGNIFICANT MEDICAL HISTORY

COMMENTS/EXPLANATIONS (by numbers): ***Staff Use Only***

Patient Name: ______________________________ Birthdate: ____________ Pt #____________

FEMALE PERSONAL HISTORY

D. MENSTRUAL HISTORY
43. Age at first period: ___________________________
44. Do you have a period each month? ☐Yes ☐No How often? ____
45. Do you have problems with: ☐ cramps ☐ emotional changes ☐ bloating ☐ heavy bleeding
46. Do you have vaginal bleeding between periods? ☐Yes ☐No

E. PREGNANCY HISTORY	
_____ Total # of pregnancies	_____ # of tubal pregnancies
_____ # of live births	__________ Date of last delivery
_____ # of miscarriages	_____ # of abortions
Complications: Pregnancy/Abortion:	
Do you plan to have children? ☐Yes ☐ No	
If yes, when? ☐ Now ☐ 1-2 years ☐ 3-5 years ☐ 5+ years	

F. CONTRACEPTIVE HISTORY - What have you used in the past?

YES	NO	METHOD	COMMENTS / PROBLEMS
		Abstinence	
		Condoms	
		Depo-Provera (Injection)	
		❒ Diaphragm ❑Cap	
		Hysterectomy	
		Implanon	
		IUD / Mirena / Paragard	
		Lunelle	
		Natural Family Planning	
		Norplant	
		Oral Contraceptives (pills)	
		Patch	
		Ring	
		Spermicide (sponge,foam, film)	
		Tubal Ligation	
		Vasectomy	
		Withdrawal	
		None	

G. SOCIAL HISTORY

YES	NO	
		47. Alcohol use: If yes, how many drinks? ___/day ___/week
		48. Anorexia, Bulimia (binging, purging)
		49. Tobacco use: If yes, ____cigs/day ____ cans/week
		50. Physical abuse: ❑Past ❑Present
		51. Sexual abuse: ❑Past ❑Present
		52. Do you feel safe with your partner?
		53. Would you like to discuss issues of abuse?

H. SEXUAL HISTORY
54. Age of first intercourse? _______
55. Have you ever had: ☐ oral sex ☐ anal sex ☐ vaginal sex
56. How many sex partners have you had: ___this year & ___ life time?
57. Have you ever had sex with: ❑Men ❑Women ❑Both
58. Has your partner had sex with: ❑Men ❑Women ❑Both ☐ Unsure
59. Has your partner had sex with someone other than you within the past year? ❒ Yes ❒ No ❒ I Don't know

YES	NO	
		60. Have you ever used needles to inject drugs?
		61. If yes, have you shared needles or "works," for example: Injecting drugs, tattooing, piercing?
		62. Have you received blood or blood products since 1978?
		63. Have you ever had a partner(s) who has ever had an STD?
		64. Have you ever had a partner(s) who has ever used IV drugs?

YES	NO	I. FAMILY HISTORY
		65. Are you adopted?
		66. If you were born between 1940 and 1970, did your mother take DES to prevent miscarriage?

67. Has a parent, sibling or grandparent had any of the following?

YES	NO	DIAGNOSIS	Relative
		Cancer (colon, breast, skin, ovary)	
		Diabetes	
		Genetic problems	
		Heart attack/stroke before age 50	
		High blood pressure	
		High blood cholesterol or fats	
		History of blood clotting disorders	
		Osteoporosis	
		Thyroid Problems	

COMMENTS/EXPLANATIONS (by numbers): ***Staff Use Only***

To the best of my knowledge the information I have provided is correct and complete

____

Patient Signature Date

____

Staff Signature Date

Date reviewed & updated: _____/_____/_______ Patient signature: ____ Staff Initials: _________

Date reviewed & updated: _____/_____/_______ Patient signature: ____ Staff Initials: _________

Date reviewed & updated: _____/_____/_______ Patient signature: ____ Staff Initials: _________

Patient Name: ____ Birthdate: ____________________ Pt#: ___________________