Women's Health History & Exam

Name _____ Age _____ Date _____

Allergies

Substance	Reaction

Current Medicines

Medication	Dosage

General

First Day of Last Menstrual Period _____

Date of Last Pap smear _____

Have you ever had an abnormal Pap smear? ___ Yes ___ No

Date of Last Mammogram _____

___ Normal results ___ Abnormal results

Do you do monthly breast self-exams? ___ Yes ___ No

Are you sexually active? ___ Yes ___ No

Menstrual History

Age you were when period started _____

Have you gone through menopause? ___ Yes ___ No

Are your periods regular? ___ Yes ___ No

Cycle: _____ days (from start to start)

How many days do your periods last? _____

Flow: ___ Light ___ Medium ___ Heavy

Do you bleed or spot in between periods? ___ Yes ___ No

Describe the intensity of pain you have with your periods:

___ None ___ Mild ___ Moderate ___ Severe

****

Medical History (check conditions you currently have or have had in the past)

___ AIDS/HIV
___ Alcoholism
___ Anemia
___ Anorexia
___ Arthritis
___ Asthma
___ Bleeding disorder
___ Blood clots
___ Bulimia
___ Cancer
___ Cataracts
___ Depression
___ Diabetes
___ Epilepsy
___ Glaucoma
___ Heart disease
___ Hepatitis
___ Herpes
___ High blood pressure
___ High cholesterol
___ Kidney disease
___ Liver disease
___ Lung disease
___ Migraines
___ Multiple sclerosis
___ Pacemaker
___ Pneumonia
___ Psychiatric care
___ Rheumatic fever
___ Sexually transmitted disease(s)
___ Stroke
___ Suicide attempt
___ Thyroid problems
___ Ulcers

Birth Control

Current form of birth control _____

Other form(s) of birth control you have used: _____

_____

_____

Pregnancy History

Number of: Pregnancies ___ Miscarriages ___

Abortions ___ Stillbirths ___

Living children ___

Number of: Vaginal deliveries ___ Cesareans ___

Do you have infertility problems? ___ Yes ___ No

If Yes, please describe: _____

_____

_____

_____

_____

_____

****

Surgeries/Hospitalizations (please list)

_____

_____

_____

_____

_____

_____

Have you ever had a blood transfusion? ___ Yes ___ No

If Yes, when? ___

Lifestyle (please note how much you consume daily)

___ Alcohol use _____

___ Street drug use _____

___ Tobacco use _____

Other: _____

Family History

Condition	Relative(s)	Condition	Relative(s)
Blood clots		High blood pressure	
Breast cancer		Kidney disease	
Colon cancer		Muscular dystrophy	
Cystic fibrosis		Osteoporosis	
DES exposure		Ovarian cancer	
Diabetes		Spina bifida	
Down's syndrome		Strokes	
Heart disease		Other:	

Review of Systems (check symptoms you currently have)

Gynecological
___ Hot flashes
___ Breast lump
___ Nipple discharge
___ Abnormal uterine bleeding
___ Abnormal vaginal discharge
___ Vaginal itching or burning
___ Pelvic pain

General
___ Fever
___ Fatigue
___ Recent weight change
___ Headaches
___ Depression

Eye, Ear, Nose, Throat
___ Visual changes
___ Hearing loss
___ Ear pain
___ Sinus problem
___ Nosebleeds
___ Bleeding gums
___ Swollen glands

Cardiovascular, Respiratory
___ Chest pain
___ Shortness of breath with exertion
___ Palpitation or irregular heart beat
___ Swelling of feet or ankles
___ Chronic cough
___ Wheezing

Genito-Urinary
___ Blood in urine
___ Frequent urination
___ Painful urination
___ Lack of bladder control

Gastrointestinal
___ Loss of appetite
___ Abdominal pain
___ Change in bowel movement
___ Diarrhea
___ Constipation
___ Nausea or vomiting
___ Rectal bleeding
___ Vomiting blood

Musculoskeletal
___ Joint pain
___ Muscle or joint weakness
___ Muscle or joint pain
___ Back pain
___ Numbness

Skin
___ Rash or itching
___ Change in mole(s)
___ Sore that won't heal

I certify that I have answered the questions on this form to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Signature of patient or guardian _____ Date _____