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Women's Care
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We request you complete the following questionnaire so that we can more effectively asses your needs. We realize that this health history is quite lengthy but its comprehensive nature will provide us with a fairly complete summary of your relevant medical history. If you have difficulty understanding or answering any of these questions, we will be happy to assist you with the problem areas at the time of your visit.

Please Complete All Items Date: _____

Name_____ Birth Date _____ Age_____

Married/Single/Divorced/ Separated/ Widowed/ Domestic Partner/ Civil Union

Reason for your visit today _____

My Last Pelvic Exam was (Date) _____ ( ) Never

My Last Pap Test was (Date and results) _____ ( ) Never

History of Abnormal Pap_____ History of HPV_____

Have You Had HPV Immunization _____ Year _____

History of Dysplasia_____ if yes, Cone Biopsy____Leep____Cryo____Laser____Colposcopy_____

Do you perform breast exams regularly? _____

My Last Mammogram was (Date and Result) _____ ( ) Never

My Last Bone Density was (Date) _____ ( ) Never

My Last Colonoscopy was (Date) _____ ( ) Never

I GYNECOLOGICAL HISTORY

Last Menstrual period began (Date) _____Normal?_____Days Lasted_____

My Flow is (Circle One) Scant/ Moderate/ Heavy

any painful periods? _____

Age at first period _____

Bleeding Between Periods? _____ Change in Cycle _____

Any Menstrual Abnormalities Concern _____

Any Bleeding after Menopause _____

Do You Have Abnormal Vaginal Discharge _____Irritation_____ Itching_____Odor _____

Do You Have Burning and/or Pain when You Pass Urine _____ Have you uncontrolled loss of urine_____

Are You Currently Attempting To Get Pregnant _____

Have You Had or Having a Difficult Time Getting Pregnant _____

Are You Having or Had Hot Flashes_____ Do You Have Concerns about Menopause _____

Do You Suffer from Vaginal Dryness _____ Other Concerns _____

Have You Had Pelvic Pain for More Than 6 months _____

Any Pain During: Intercourse _____ Menstrual Cycle _____ Urination _____

Have You Had Bleeding During or After Sex _____

II Sexual History

Sexual Orientation (circle one) Heterosexual/ Homosexual/ Bisexual

Current # of Sexual Partners _____ Lifetime # of Sexual Partners _____

Please check any of the following that you have had:

Herpes _____Chlamydia_____ Gonorrhea_____ Syphilis____ Trichomoniasis_____

Genital Warts _____

Other Sexually Transmitted Disease (STD) _____

Pelvic Inflammatory PID _____

HPV (Human Papilloma Virus)_____

HIV ____

Often Questions About Sex and /or Relationships Are Hard To Ask, But We Are Here To Help Answer Any Questions You May Have.

Do You Wish to Discuss Any of These Now? Yes _____ No ____ Not Sure _____

III Obstetric History

Total # of Pregnancies _____ # of Miscarriages If Any _____ # of Terminations Of Pregnancy _____

Of Living Children _____

My Past Pregnancy History is: (Please include live births and still births)

Born: Month/Year	**Place**	**Weight**	**Sex**	**Type of Delivery** "V" Vaginal "C" C-Section	**Complications**
1					
2					
3					
4					
5					
6					

IV Birth Control

Put an "X" After the Method or Methods You Have Used """ If You Are Currently Using

Method	**Now**	**Past**	**Length Used**	**Any Problems**
Pills				
IUD				
Condoms (Rubbers)				
Diaphragm & Jelly				
Rhythm/Natural				
Method	**Now**	**Past**	**Length Used**	**Any Problems**
Withdrawal				
Spermicides				
Cervical Cap				
Depo-Provera				

Norplant _____

Sterilization (Tubal) _____

Sterilization (Vasectomy) _____

Other _____

V. Peri Menopausal/ Menopausal

Symptoms	**Often**	**Occasional**	**Never**
Night Sweats			
Hot Flashes			
Sleep Disturbances			
Vaginal Dryness			
Urinary Leakage			
Inability to Concentrate			
Memory Loss			
Moodiness			
Anxiety			
Depression			
Decrease in Libido			
Decrease in Energy/Lethargy			

Have You Been Taking Medications/Supplements for Your Menopausal Symptoms

IX Personal Health History

I Have/Have Had (please Check)		I Have/Had Vaccination for (please date)
( ) Chicken Pox	( ) Kidney Disease	( ) MMR
( ) Cancer	( ) Urinary Tract Infection (UTI)	( ) Hepatitis B
( ) Blood Transfusion	( ) Depression	( ) Tetanus
( ) Anemia	( ) Thyroid Problems	( ) Influenza Vaccine
( ) Severe Headaches	( ) Breast Lump(s)	( ) Pneumococcal Vaccine

( ) Epilepsy ( ) Nipple Discharge ( ) Hair Loss

( ) High Blood Pressure ( ) Bowel Disorder ( ) Hair Increase

( ) Heart Disease ( ) Stomach Ulcers or Hiatal Hernia ( ) Skin Problems

( ) Rheumatic Fever ( ) Asthma/respiratory Disease ( ) Gallbladder Disease

( ) Arthritis ( ) Varicose Vein/Thrombophlebitis ( ) Liver Disease

( ) Diabetes ( ) Hyperlipidemia High Cholesterol ( ) Breast cancer

( ) Colon cancer ( ) uterine cancer ( ) cervical cancer

( ) Ovarian cancer

Any Other Serious Medical illness: _____

_____

Any Hospitalizations

1._____
2._____
3._____
4._____
5._____

Surgeries (Include type and year)

1._____
2._____
3._____
4._____
5._____

Allergies (Please List Drug and/or Substance Allergies) ( ) None

( ) Environmental _____

( ) Medications _____

Current Vitamins/Herbs/Supplements _____

_____

Current Medications (List Doses and Frequency Prescribed or Over the Counter) _____

_____

_____

_____

X. Family Health History

I Have Parents, Grandparents, Brother/Sister, Aunt/Uncle, Cousin With:

(Check The Disease and List The Relative With The Problem)

( ) Heart Attack _____ ( ) Stroke _____

( ) High Blood Pressure _____ ( ) Hyper lipidemia/ High cholesterol_____

( ) Diabetes _____ ( ) Cancer (include type) _____

( ) Breast cancer ( ) Colon cancer

( ) uterine cancer ( ) cervical cancer

( ) Ovarian cancer

( ) Osteoporosis _____ ( ) Inherited Disorders _____

( ) Thyroid Disease _____ ( ) Multiple Gestation (Twins/Triplets) _____

( ) Alzheimer's _____ ( ) Obesity _____

( ) Mental Illness _____ ( ) Other _____

Other (Please specify) _____

VI Habits

I Smoke _____ Pack(s) Per Day and I Have for _____ Years

I Used To Smoke _____ Pack(s) Per Day and Quit _____ Months/Years Ago

I Have _____ Drinks/Beer a Day/Week (Circle)

I Have Concerns with My Drinking Habits Y / N

Any Over the Counter Medicines/Street Drugs I Take Are (Please List and include Sleep Aids, Diet Pills, Aspirin, Tranquilizer, etc.) _____

I am a recovering Alcoholic Y / N I Am A Recovering Drug User Y / N

VII Diet History

I Have Had Problems with Excessive Weight Gain or Loss Yes _____ No_____

I Have Had Problems Controlling Food Intake (Binging/Purging/Anorexia/Bullmia) Yes___ No_____

VIII Exercise History

Do you Exercise Regularly Yes___ No _____

Please Describe Type of Exercise _____Frequency _____

IX Social History

Have You Ever Been Hit, Slapped, Kicked or Otherwise Physically Been Hurt By Someone

Yes _____ No_____

If the Answer Was Yes Do You Wish to Discuss This Yes ___ No __

Have You Ever Been Forced To Have Sex When You Did NOT Want to Yes _____ No_____