Women's Health Center

Health History Form

Patient Name: _____ DOB: __/__/____

Age: _____ Today's Date: _____ Preferred Pharmacy: _____

Birth Sex: ☐ Male ☐ Female

Do you have a regular (Family) Doctor? ☐ Yes ☐ No If Yes, who? _____

With Whom Do You Live? _____ Any Pets? ☐ Yes ☐ No If Yes, Type? _____

Gender Identity:	Sexual Orientation:
☐ Male ☐ Female ¨ Trans: Female to Male ☐ Trans: Male to Female ☐ Genderqueer ☐ Other: _____ ☐ Decline to respond	☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Other ☐ Don't know ☐ Decline to respond

Medications (include supplements, inhalers, birth control and over the counter medications):

Name	Strength	How often?

Latex Allergy? ☐ Yes ☐ No

Allergies (especially medications, specify reaction):

_____

Past Surgical History (please include year):

Appendectomy	Gall Bladder Removal	Tonsillectomy
Hernia Repair	Hysterectomy	Mastectomy
Ovaries	Pacemaker	Heart Stents
Tubal Ligation	Cystoscopy	D&C
LEEP	Salpingectomy	Endometrial Ablation
Anterior (Bladder) Repair	Posterior (Bowel) Repair	TOT
Hysteroscopy		

List of other surgical history

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Trauma, Hospitalizations, or Serious Illnesses:

*Have you seen other medical providers for routine or specialty care? ☐ Yes ☐ No

1. Provider Name:	Date:	Seen for:
2. Provider Name:	Date:	Seen for:
3. Provider Name:	Date:	Seen for:
4. Provider Name:	Date:	Seen for:

*The care team will ask you to sign a release so we may obtain your records from these providers. Access to these records ensures we can give you the best care possible.

Health Hazards (quantity, frequency, and duration of use):
Alcohol: ☐ Yes ☐ No If yes, how often? _____
**Tobacco: ☐ Yes ☐ No If yes, how often? _____What substance(s)? _____
**If you do not use tobacco now, have you in the past? ☐ Yes ☐ No | When did you quit? _____
Marijuana ☐ Yes ☐ No If yes, how often? _____
Caffeine: ☐ Yes ☐ No If yes, how often? _____
Drugs: ☐ Yes ☐ No If yes, how often? _____What substance(s)? _____
Vape: ☐ Yes ☐ No If yes, how often? _____

Occupational Concerns (Work Exposure): Your Occupation (Current or former): _____

Job Status: ☐ Active ☐ Retired

Menstrual History:
Age of First Menstrual Period: _____
Last Menstrual Period: _____
Interval of cycle (start one period to start of next) _____
Duration (# of days of bleeding) _____
Usual Flow: ☐ Light ☐ Moderate ☐ Heavy
Pain: ☐ None ☐ Mild ☐ Moderate ☐ Severe
Spotting/Bleeding between periods? ☐ No ☐ Yes
Sanitary Protection? ☐ Pads ☐ Tampons ☐ Both ☐ Menstrual Cup
Any previous abnormal PAPS? ☐ Yes ☐No
Current Method of Birth Control _____ Problems? _____
Prior Method of Birth Control_____ Problems? _____

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Sexual History:
Sexually active? ☐ Yes ☐ Not Currently ☐ Never
Any problems with sex life? ☐ Yes ☐ No
# of Sex partners (in your lifetime) _____
Age at first intercourse? _____

Bladder History:
Any problem with leakage or bladder control? ☐ Yes ☐No

Screenings/ Tests: Have you had any of the following?
Colonoscopy: ☐ Yes/Date: _____/_____ ☐ No
Recent Labs: ☐ Yes/Date: _____/_____ ☐ No
Bone Density: ☐ Yes/Date: _____/_____ ☐ No
Mammogram: ☐ Yes/Date: _____/_____ ☐ No
Pap Smear: ☐ Yes/Date: _____/_____ ☐ No

Pregnancies: (including miscarriages, abortions & tubal pregnancies)

Number	Year	Sex	Weight	Complications Fetal & Maternal	Vag./C-Section/ Miscarriage	Health (child)
1						
2						
3						
4						
5						
6						

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Patient Name:_____ DOB:____/____/_____

Medical History: (Please circle which problem applies)

Personal Medical History			Family Medical History		
Yes	No	Medical Problem	Yes	No	Relationship
		Diabetes Mellitus			
		Hypertension (High Blood Pressure)			
		Hyperlipidemia (High Cholesterol)			
		Heart Disease (Heart Murmur, Heart Attack, Angina)			
		Blood Transfusions			
		Asthma			
		Blood clots in legs or lungs			
		Liver disease (Hepatitis, Jaundice)			
		Seizure, stroke, Migraines			
		Mental Illness (Depression, Anxiety)			
		Abdominal Problems (Peptic Ulcer, Reflux, Colitis, Pancreatitis, Gallbladder)			
		Kidney Stones, Urinary Tract Ailments			
		Anemia, Sickle Cell, Clotting disorder			
		Arthritis			
		Thyroid disease			
		Cancer – What type? _____			
		Gonorrhea/ Chlamydia/PID			
		HPV/Genital Warts/ Herpes/ Syphilis			
		Uterine Fibroids			
		Endometriosis			
		MRSA			
		Other:			