Women's Healthcare & Wellness

Name_____ Date of Birth____/____/____ Today's Date_____
〔Single 〔Married 〔Separated 〔Divorced 〔Widowed Referred By_____

Medical History Have you ever had any of the following?

❑ Anemia	❑ Blood Clots in Lungs/Legs	❑ Chicken Pox	❑ Pneumonia
❑ Heart Disease/Attack	❑ Gall Bladder Disease	❑ Epilepsy/Seizures	❑ Tuberculosis
❑ High Blood Pressure	❑ Liver Disease/Hepatitis	❑ Migraines	❑ Sickle Cell Disease
❑ Stroke	❑ Kidney Infections	❑ Depression/Anxiety	❑ Thyroid Problem
❑ High Cholesterol	❑ Bladder Infections	❑ Drug or Alcohol Problem	❑ Blood Transfusion
❑ Mitral Valve Prolapse	❑ Pelvic Infections	❑ Diabetes	❑ Genetic Condition
❑ Bleeding Problems	❑ Arthritis	❑ Asthma	❑ Cancer

List all medications you are currently taking, including over-the-counter medications, vitamins and herbal remedies:

_____ _____ _____ _____
_____ _____ _____ _____

List any allergies to medications: _____ 〔No Known Allergies

Surgical History Please list all surgeries with dates:

_____ _____
_____ _____

Obstetrical History

〔Check here if you have never been pregnant 〔Check here if you have adopted children and list names below
Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopics (tubal), and abortions:

Year	M/F	Weight	Type of Delivery	Length of Pregnancy	Problems (e.g., preterm labor, diabetes, high blood pressure)	Name/Age

Gyn History

Age of first period _____
Age of last period _____
Cycle length: every _____ days
lasting _____ days

Periods are: ❑ Regular ❑ Irregular ❑ Painful ❑ Not really bothersome

Flow is: ❑ Light ❑ Light to moderate ❑ Moderate to heavy ❑ Very heavy

Are you sexually active? ❑ Yes ❑ No ❑ virginal

Sexual preference: ❑ heterosexual ❑ homosexual ❑ bisexual

New partners? 〔yes 〔no
Number of lifetime partners _____

Method of Birth Control: ❑ condoms ❑ pills ❑ patch ❑ vaginal ring ❑ tubal/Essure ❑ IUD ❑ partner with vasectomy ❑ natural family planning ❑ other ❑ none

Have you ever had any of the following STDs? ❑ Chlamydia ❑ Gonorrhea ❑ Herpes ❑ HPV ❑ Syphilis ❑ Trichomonas ❑ HIV ❑ Hepatitis B ❑ Hepatitis C ❑ Never had any

Have you ever had any of the following? ❑ Fibrocystic breasts ❑ Ovarian cysts ❑ Endometriosis ❑ Uterine fibroids

Date of last pap smear_____ 〔normal 〔abnormal
Have you ever needed any of the following for an abnormal pap? ❑ Colposcopy ❑ LEEP/Laser/Conization ❑ Cryosurgery ❑ No

Date of last mammogram _____ ❑ Normal ❑ Abnormal ❑ Never had one
Date of last bone density _____ ❑ Normal ❑ Osteopenia ❑ Osteoporosis ❑ Never had one
Date of last colonoscopy_____ Never had one

Family History

Please list any close relatives with a history of the following:

	Relative/Age at Diagnosis		Relative
❑ Breast cancer		❑ High blood pressure	
❑ Ovarian cancer		❑ Diabetes	
❑ Uterine cancer		❑ Heart Disease (heart attack,	
❑ Colon cancer		stroke, bypass surgery)	
		Alzheimer's Disease	

Social History

Alcohol use	❑ Yes	❑ No	If yes, _____drink(s) per day/week/month
Tobacco use	❑ Yes	❑ No	If yes, _____ pack(s) per day for _____ years
Street drug use	❑ Yes	❑ No	Type and frequency_____
Exercise	❑ Yes	❑ No	Type and frequency_____
Caffeine	❑ Yes	❑ No	If yes, _____ caffeinated drinks (coffee, tea, soda) per day/week
Sexual Abuse	❑ Yes	❑ No	If yes, are you safe now? 〔yes 〔no Counseling? ❑yes 〔no
Physical Abuse	❑ Yes	❑ No	If yes, are you safe now? 〔yes 〔no Counseling? ❑yes 〔no
Emotional Abuse	❑ Yes	❑ No	If yes, are you safe now? 〔yes 〔no Counseling? ❑yes 〔no

SYMPTOMS (PLEASE CHECK MARK)	NEVER	MILD	MODERATE	SEVERE
Depressive Mood				
Anxiety				
Fatigue				
Memory Loss				
Mental Confusion				
Decreased Sex Drive/Libido				
Difficult to climax sexualy				
Sleep problems				
Mood changes/irritability				
Tension				
Migraine/severe headaches				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Vaginal itching/buring				
Hot flashes				
Night sweats				
Leakage of urine with stress				
Urinary urgency				
Dry and wrinkled skin				
Hair is falling out				
Cold all the time				
Joint pain				
Swelling all over the body				