

WOMEN'S HEALTH SPECIALISTS

HISTORY

ACCOUNT # _____

Last Name _____ First Name _____ DOB _____ AGE _____

Minor _____ Single _____ Engaged _____ Married _____ Divorced _____ Widowed _____

Husband: _____ DOB _____

Referred by: _____ Occupation _____ Primary Language _____

Reason you made appointment _____

Allergies _____ Religion _____

Ethnic background _____

MENSTRUAL HISTORY

1. Age periods started (menarche) _____
2. Do you have normal periods? _____ *If so you may skip to #13*
If you are post-menopausal, skip to #14
3. How many days apart are your cycles? _____ (menstrual interval)
4. How many days do your periods last? _____ (duration)
5. How would you describe the flow? Light _____ Moderate _____ Heavy _____ **YES NO**
6. Do you have painful periods? _____
7. Do your cramps start before _____ during _____ or after _____ your bleeding begins?
8. What do you take for the pain _____?
9. Do you miss work/school/activities during your periods? _____
10. Have you felt cramping/pain between periods? _____ (ovulatory pain)
11. Do you have spotting/bleeding between periods? _____
12. Do you have breast tenderness/moodiness/bloating prior to periods? _____

CONTRACEPTION

13. What do you use for birth control now? _____
- In the past, I have used:
- | | | | |
|---|------------------------------|-----------------------------|-------------------------------------|
| Birth control pills | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Discontinued for what reason? _____ |
| Barrier methods
(condoms, spermicides,
diaphragm) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Discontinued for what reason? _____ |
| Depo-Provera | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Discontinued for what reason? _____ |
| Norplant | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Discontinued for what reason? _____ |
| Permanent Sterilization
(tubal ligation, vasectomy) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| IUD | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Discontinued for what reason? _____ |
| Rhythm
(Periodic abstinence) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Discontinued for what reason? _____ |
| Withdrawal | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Discontinued for what reason? _____ |

MENOPAUSE

14. Approximate age of menopause _____ Natural _____ Surgical _____ **YES NO**
15. Have you experienced post-menopausal bleeding/spotting? _____
16. Do you presently take hormones? _____
17. Do you have bleeding as a result? _____
18. Have you taken hormones in the past? How many years? _____
19. Reason for discontinuation _____

GYNECOLOGIC HISTORY

- 20. Have you ever been told you had:
- 21. An abnormal Pap smear YES NO How were you treated? _____
- 22. Endometriosis YES NO How were you treated? _____
- 23. Fibroids (Uterine Leiomyomata) YES NO How were you treated? _____
- 24. Infection of the tubes or ovaries (PID, Gonorrhea, Chlamydia) YES NO How were you treated? _____
- 25. Genital warts (Condyloma, Human Papilloma Virus) YES NO How were you treated? _____
- 26. Herpes YES NO How were you treated? _____
- 27. Vaginal Cysts (Bartholin gland or Gartner's Duct) YES NO How were you treated? _____
- 28. Vulvar Abscess (Bartholin gland) YES NO How were you treated? _____
- 29. Vaginal infections (Trichomonas, Yeast, Bacterial) YES NO How were you treated? _____
- 30. DES exposure YES NO How were you treated? _____
- 31. Malformation of the genital or urinary tract YES NO How were you treated? _____

GYNECOLOGIC REVIEW OF SYSTEMS:

- | | YES | NO |
|--|--------------------------|--------------------------|
| 32. Are you sexually active? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Do you have spotting/bleeding after intercourse? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Do you have pain with intercourse? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Do you have any problems with intercourse you wish to discuss? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Do you have any unusual vaginal discharge? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Do you have any vaginal odor? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Do you have external or internal itching/burning? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Do you have any lumps in your breasts? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you have nipple discharge when not breast feeding? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you have chronic pelvic pain? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Do you have any bladder problems? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Do you have any bowel problems? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

OBSTETRICAL HISTORY:

- 44. Do you think you are pregnant? _____ YES NO
- 45. If you have never been pregnant skip to #58
- 46. How many times have you been pregnant? _____
- 47. How many miscarriages _____ ectopic pregnancies _____ terminations _____ have you had?
- 48. Did you have a "D & C" following any of the above? YES NO
- 49. How many premature births _____ stillbirths _____ twin pregnancies? _____

PAST PREGNANCIES

DATE MO/YR	GA WEEKS	BIRTH WEIGHT	NATURAL/FORCEPS/ CESAREAN SECTION	ANESTHESIA	PLACE OF DELIVERY	DOCTOR

- | | YES | NO |
|--|--------------------------|--------------------------|
| 50. Did you have trouble conceiving? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 51. Did you use any fertility drugs? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 52. Have you ever had a "molar pregnancy"? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 53. Did you have any complications of pregnancy, labor, delivery or post-partum? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Were you ever told you had:

- | | | |
|--|--------------------------|--------------------------|
| 54. Insulin dependent Gestational diabetes? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 55. Pre-eclampsia/Eclampsia? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 56. Post-Partum Hemorrhage? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 57. Extensive Cervical or Vaginal Lacerations? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

PAST MEDICAL HISTORY:

- | | Self | Which of your relatives? | | |
|--|-------|--------------------------|--------------------------|--------------------------|
| 58. Breast Cancer | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 59. Uterine Cancer | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 60. Cervical Cancer | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 61. Ovarian Cancer | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 62. Colorectal Cancer | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 63. Other Cancer | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 64. Diabetes | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 65. High Blood Pressure | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 66. Heart Disease | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 67. Stroke / Alzheimer's Disease | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 68. Lung Disease | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 69. Kidney Disease | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 70. Liver/Gallbladder Disease | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 71. Thyroid Disease | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 72. Gastrointestinal Disease | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 73. Bone/Joint Disease | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 74. Blood Disease/Anemia | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 75. Seizure Disorder | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 76. Headaches-Migraine or tension | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 77. Psychiatric Illness | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 78. Human Immunodeficiency Virus (AIDS) | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 79. Have you ever had a blood transfusion? _____ | | | <input type="checkbox"/> | <input type="checkbox"/> |
| What reason? _____ | | How many units _____ | | |
| 80. Do you have a heart murmur? _____ | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 81. Do you take antibiotics prior to dental procedures? _____ | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 82. Do you have a pacemaker? _____ | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 83. Do you have an irregular heart rate or rhythm? _____ | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 84. Do you have any skin diseases? _____ | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 85. Have you been hospitalized for anything else not previously discussed? _____ | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 86. Who is your primary physician? _____ | | | <input type="checkbox"/> | <input type="checkbox"/> |

PAST SURGICAL HISTORY:

- | Have you had any of these operations? | Date | Surgeon | | |
|--|-------|---------|--------------------------|--------------------------|
| 87. Abdominal or Vaginal Hysterectomy | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 88. Removal of Tubes and Ovaries | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 89. Bilateral Tubal Ligation (tubes tied, cut, burned) | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 90. Bladder Surgery | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 91. Cervical Cone Biopsy/Cryosurgery/Leep | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 92. Laser surgery of Vulva/Vagina/Cervix | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 93. Exploratory Laparotomy (abdominal surgery) | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 94. Mastectomy Right, Left or Both (breast removed) | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 95. Breast Biopsy Right, Left or Both | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |

	Date	Surgeon	YES	NO
96. Breast Reduction or Augmentation	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
97. Appendectomy (appendix removed)	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
98. Cholecystectomy (gall bladder removed)	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
99. Thyroidectomy (thyroid removed)	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
100. Bowel Resection (large or small bowel)	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
101. Heart Surgery	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
102. Tonsils or Adenoids Removed	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
103. Hernia Surgery	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
	_____	_____		
	_____	_____		

MEDICATIONS

105. Are you allergic to any medications? _____
 If so, to what, and what was your reaction? _____

List the medications you take on a regular basis including vitamins, laxatives, birth control pills, mineral supplements etc. If you have a list we will be happy to copy it.

DRUG	DOSAGE	HOW MANY TIMES PER DAY	INDICATION
1.			
2.			
3.			
4.			
5.			
6.			

	YES	NO
106. Do you smoke cigarettes now? _____	<input type="checkbox"/>	<input type="checkbox"/>
107. Have you in the past? _____	<input type="checkbox"/>	<input type="checkbox"/>
108. How many cigarettes per day _____? How many years all together? _____	<input type="checkbox"/>	<input type="checkbox"/>
109. Do you drink alcohol? _____	<input type="checkbox"/>	<input type="checkbox"/>
110. Have you in the past? _____	<input type="checkbox"/>	<input type="checkbox"/>
111. How many ounces per week _____? How many years? _____	<input type="checkbox"/>	<input type="checkbox"/>
112. Do you drink caffeinated beverages (coffee, tea, sodas)? _____	<input type="checkbox"/>	<input type="checkbox"/>
113. On an average day, how many cups/glasses do you consume? _____	<input type="checkbox"/>	<input type="checkbox"/>
114. Do you now, or have you in the past ever used any recreational drugs or abused prescription drugs? _	<input type="checkbox"/>	<input type="checkbox"/>
115. Do you exercise regularly? _____	<input type="checkbox"/>	<input type="checkbox"/>

Have you had any of the following studies in the past 12 months?:

	YES	NO
116. Mammogram _____	<input type="checkbox"/>	<input type="checkbox"/>
117. Breast Ultrasound _____	<input type="checkbox"/>	<input type="checkbox"/>
118. Pelvic Ultrasound _____	<input type="checkbox"/>	<input type="checkbox"/>
119. Sigmoidoscopy _____	<input type="checkbox"/>	<input type="checkbox"/>
120. Barium Enema _____	<input type="checkbox"/>	<input type="checkbox"/>
121. Upper GI _____	<input type="checkbox"/>	<input type="checkbox"/>
122. Colonoscopy _____	<input type="checkbox"/>	<input type="checkbox"/>
123. Stool check for blood _____	<input type="checkbox"/>	<input type="checkbox"/>
124. Laboratory work of any kind	<input type="checkbox"/>	<input type="checkbox"/>

REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms?

Constitutional:		Gynecological:	
	Fever		Bleeding or pain with intercourse
	Chills		Unusual vaginal discharge or odor
	Sweats		Vulvar or vaginal itching or burning
	Weight change – gain or loss		Pelvic
	Weakness		
	Fatigue	Urinary:	
			Painful urination
Eyes:			Frequent urination
	Change in vision		Urinary urgency
			Blood in urine
Ears, Nose, Mouth, Throat:			Urinary incontinence
	Change in hearing		Getting up at night to urinate
	Nose bleeds		
	Sore throat	Musculoskeletal:	
	Dry mouth		Back pain
			Weakness
Cardiovascular:			Joint pain, stiffness, swelling
	Dizziness		
	Shortness of breath	Intergumentary / Breast:	
	Chest pain		Nodules
	Loss of consciousness		Change in moles, freckles
	Palpitations		Change in hair – growth, loss, texture
			Breast lumps
Respiratory:			Breast nipple discharge
	Chest pain		Breast pain
	Cough – productive or dry		
	Shortness of breath	Neurological / Psychiatric:	
	Wheezing		Memory change
			Depression
Gastrointestinal:			Anxiety
	Abdominal pain		Mood swings
	Nausea, vomiting		Numbness or tingling
	Change in bowel habits		
	Change in appetite	Endocrine:	
	Dark or bloody stool		Weight change
	Indigestion		Excessive thirst, urination
	Constipation or diarrhea		Tremor
			Cold or heat intolerance
Hematologic / Lymphatic:			
	Swollen lymph glands		I DO NOT HAVE ANY OF THESE SYMPTOMS AT THIS TIME.
	Easy bruisability		