Confidential Health History

Physicians for Women
Obstetrics & Gynecology

Name _____

Date of Birth _____ Age ____

Social Security Number _____

Primary Physician _____

Physicians for Women
Obstetrics & Gynecology

Please list medications ***(including herbals)*** and dosage you are currently taking:	Please list drug allergies and reaction (e.g. sulfa = rash):
_____ _____ _____ _____ _____	_____ _____ _____ _____ _____

Past Medical History - **Circle** All That Apply:		**Past Surgical History** - Please note approximate year for applicable surgeries:	
Abnormal Uterine Bleeding	Anemia	Hysterectomy	Year _____
Abnormal PAP Smear	Arrhythmia	Laparoscopy	Year _____
Fibroids	Heart Disease	Hysteroscopy	Year _____
Herpes / Other STD	High Blood Pressure	Bladder Repair	Year _____
Infertility	High Cholesterol	Appendectomy	Year _____
HIV or AIDS	Asthma	Cesarean Section	Year _____
Breast Disease/Lumps	Tuberculosis	Ovaries Removed	Year _____
GERD / Hiatal hernia	Bladder Infection	Tubal Banding? Ligation	Year _____
Irritable Bowel Disease	Incontinence	Cervical Cone Biopsy	Year _____
Colitis or Inflammatory	Kidney Disease or Stone	Vaginal Wall Repair	Year _____
Bowel Disease	Anxiety Disorder	Gallbladder Removal	Year _____
Hepatitis	Migraine Headaches	Tonsillectomy/Adenoidectomy	Year _____
Stomach Ulcers	Depression		
Diabetes	Cancer (type) _____	Other:	
Thyroid Disorder	Other _____	_____	Year _____
		_____	Year _____

List any other health problems:

_____
_____
_____

Reproductive History

- ✓ Age at first menstrual period _____
- ✓ Average number of days from the **beginning** of one cycle to the **beginning** of next cycle _____
- ✓ Number of pregnancies _____
- ✓ Number of live births _____
- ✓ Number of miscarriages /abortions ____ /____

- ✓ Date of last menstrual period
  _____ /_____ /_____
- ✓ Number of days your flow lasts _____
- ✓ Any bleeding between cycles? Yes / No
- ✓ Are you currently sexually active? Yes / No
- ✓ Any bleeding after intercourse? Yes / No
- ✓ Birth control method: _____
- ✓ Satisfied with current method? Yes / No
- ✓ Planning a pregnancy in the next year? Yes / No

Reproductive History - continued				
Birth Mo/ Year	**Sex**	**Birth Weight**	**Term or Preterm**	**Type of Delivery (Vaginal or C/S)**

Family History

Please indicate any ***immediate*** family members who have any of the following:

Diabetes _____
Heart Disease _____
High Blood Pressure _____
Kidney Disease _____
Thyroid Disease _____
Cancer (type) _____
Lung Disease _____
Inheritable Anemia / Blood Disorders _____
Depression/Mental Illness/Alzheimer's _____
Other: _____

Social History

As health care providers, we realize many people live in less than ideal situations, and it is our responsibility to offer help if you are in an unsafe environment. Please let us know if you do not feel safe in your current relationship or would like a referral to a mental health or legal professional.

- ✓ Do you feel safe in your relationship? Yes / No
- ✓ Are you being hurt in any way? Yes / No
- ✓ Have you ever been forced to have sex against your will? Yes / No
- ✓ Do you have anything you want to tell us that might influence your care? Yes / No

_____

Preventive Health Behaviors	Yes	No
Do you?		
Smoke (if yes, how many / day _____)	_____	_____
Drink alcohol (if yes, how many / week _____)	_____	_____
Use recreational drugs	_____	_____
Perform self-breast exams monthly	_____	_____
Use sunscreen daily	_____	_____
Have eye exams annually	_____	_____
See a dentist every 6-12 months	_____	_____
Use seatbelts consistently	_____	_____
Exercise regularly	_____	_____

		Yes	No	N/A	Don't Know
<u>Vaccines current?</u>					
Tetanus	Year of last one _____	_____	_____	_____	_____
Diphtheria	Year of last one _____	_____	_____	_____	_____
Hepatitis	Year of last one _____	_____	_____	_____	_____
Flu	Year of last one _____	_____	_____	_____	_____
<u>Ever had?</u>		_____	_____	_____	_____
a mammogram	Year of last one _____	_____	_____	_____	_____
a colonoscopy	Year of last one _____	_____	_____	_____	_____
a cholesterol screening	Year of last one _____				
a bone mineral density	Year of last one _____				

Patient Signature: _____ *Date:* _____