**Print in Color or Grayscale Only**
Using Adobe Acrobat Reader 8.0 or later

# Women's History

Please answer every question.

## Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

## MEDICAL HISTORY

**Please indicate if YOU have a history of the following:**

- Abnormal Mammogram
- Abnormal Pap Smear
- Acne
- AIDS
- Anaphylactic Shock
- Anemia (unspecified)
- Anemia (sickle cell)
- Anxiety Disorder
- Asthma

**Bladder:**

- Blood in Urine (hematuria)
- Chronic Bladder Infections
- Interstitial Cystitis
- Protein in Urine (proteinuria)

**Bleeding:**

- Heavy Periods
- Infrequent Periods
- Irregular Periods
- Painful Periods
- Post Menopausal Bleeding

**Cancer:**

- Breast (being treated)
- Breast (treatment completed)
- Cervical (being treated)
- Cervical (treatment completed)
- Colon (being treated)
- Colon (treatment completed)
- Lung (being treated)
- Lung (treatment completed)
- Chronic Fatigue Syndrome
- Connective Tissue Disease
- Constipation (chronic)
- COPD
- Crohn's Disease
- Deaf (need interpreter)
- Depression

**Diabetes:**

- Gestational (during pregnancy)
- Type 1 (juvenile)
- Type 2 (adult onset)

- Dialysis (current urinary / kidney)
- Eating Disorder (unspecified)
- Elevated Cholesterol (lipids)
- Emphysema
- Endometriosis (site unspecified)
- Fibromyalgia
- Gallstones (cholelithiasis)
- Glaucoma
- Goiter
- Grave's Disease

**Heart:**

- Cardiomyopathy
- Coronary Artery Disease
- Heart Attack
- Heart Murmur
- Irregular Heartbeat (arrhythmia)

- Hepatitis
- Herpes (genital)
- Malignant Hyperthermia
- Migraines
- MRSA (treatment completed)
- Multiple Sclerosis (MS)
- Muscular Dystrophy
- Myasthenia Gravis
- Osteoarthritis (joint disease)
- Osteopenia
- Osteoporosis
- Painful Intercourse (dyspareunia)
- Painful Urination (dysuria)
- Paralysis (unspecified)
- Paranoid Schizophrenia
- Parathyroid Gland Disorder
- Parkinson's
- Pelvic Prolapse
- Polycystic Ovarian Syndrome
- Postpartum Depression
- Post-Traumatic Stress Disorder
- Pulmonary Edema
- Pulmonary Embolism
- Radiation (completed)
- Rheumatoid Arthritis
- Seizures
- Skin Disorder
- Sleep Apnea
- Sleep Disorder
- Stroke
- Tuberculosis (current treatment)

*please fold on dotted line*

- Ovarian (being treated)
- Ovarian (treatment completed)
- Skin (being treated)
- Skin (treatment completed)
- Thyroid (being treated)
- Thyroid (treatment completed)
- Uterine (being treated)
- Uterine (treatment completed)
- Vulva / Perineum (being treated)
- Vulva / Perineum (treatment completed)
- Cataracts
- Herpes (oral)
- HIV Infection (no symptoms)
- Hypertension (high blood pressure)
- Hyperthyroidism (overactive)
- Hypothyroidism (underactive)
- Infertility (female)
- Irritable Bowel Syndrome (IBS)
- Kidney Stones
- Legally Blind
- Lupus
- Lyme Disease
- Tuberculosis (past treatment)
- Ulcerative Colitis
- Urine Leakage (incontinence)
- Uterine Fibroids
- Vaginal Infections (chronic)
- Varicose Veins (lower body)
- von Willebrand's Disease
- Vulva Rash (lichen sclerosus)
- Vulvar Pain (vulvodynia)
- Other
- **NONE of the ABOVE**

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## ALLERGIES

**Please mark any of the following that apply:**

- ◯ **NO KNOWN DRUG ALLERGIES**
- ◯ **NO LATEX ALLERGY**
- ◯ Latex Allergy
- ◯ Penicillins
- ◯ Sulfa (sulfonamide antibiotics)
- ◯ Betadine
- ◯ Egg
- ◯ Peanut Oil
- ◯ Other

## PREVENTIVE CARE / WELLNESS

| | | | | |
|---|---|---|---|---|
| **Last pap smear?** | NONE ◯ | less than 1 year ◯ | 1-5 years ◯ | more than 5 years ◯ |
| **Last mammogram?** | NONE ◯ | less than 1 year ◯ | 1-5 years ◯ | more than 5 years ◯ |
| **Last DXA scan** (bone density)**?** | NONE ◯ | less than 1 year ◯ | 1-5 years ◯ | more than 5 years ◯ |
| **Last cholesterol level check?** | NONE ◯ | less than 1 year ◯ | 1-5 years ◯ | more than 5 years ◯ |
| **Last colonoscopy?** | NONE ◯ | less than 1 year ◯ | 1-5 years ◯ | more than 5 years ◯ |
| **Last fecal occult blood test?** | NONE ◯ | less than 1 year ◯ | 1-5 years ◯ | more than 5 years ◯ |

## SURGICAL HISTORY

**Please mark all surgeries you have had:**

*please fold on dotted line*

- ◯ Amputation
- ◯ Aneurysm Repair
- ◯ Appendectomy
- ◯ Arm / Shoulder / Wrist / Hand Surgery
- ◯ Back / Spine Surgery
- ◯ Bladder Surgery
- ◯ Brain / Head Surgery
- ◯ Breast Augmentation
- ◯ Breast Biopsy
- ◯ Breast Cyst (aspiration / removal)
- ◯ Breast Lumpectomy
- ◯ Breast Reconstruction
- ◯ Breast Reduction
- ◯ Breast Removal (mastectomy)
- ◯ Cardiac Bypass
- ◯ Cardiac Valve Replacement
- ◯ Colon Resection
- ◯ Cosmetic Surgery
- ◯ C-Section
- ◯ Cystocele Repair (prolapse)
- ◯ D & C (dilation & curettage)
- ◯ Ear / Neck / Throat / Face Surgery
- ◯ Endometrial Ablation
- ◯ Fallopian Tube / Ovary Removal
- ◯ Fibroid Removal (myomectomy)
- ◯ Gallbladder Removal (cholecystectomy)
- ◯ Gastric Bypass
- ◯ Hemmorhoidectomy
- ◯ Hernia Repair
- ◯ Hysterectomy (uterus & cervix)
- ◯ Hysterectomy (uterus only)
- ◯ Hysteroscopy
- ◯ In Vitro Fertilization (IVF)
- ◯ Joint Replacement
- ◯ **I Have Had NO SURGERIES**
- ◯ Kidney Surgery
- ◯ Leg / Hip / Ankle / Foot Surgery
- ◯ Liver Surgery
- ◯ Lung Surgery
- ◯ Metal Implant(s)
- ◯ Ovarian Cyst (drain / removal)
- ◯ Pacemaker
- ◯ Pancreatic Surgery
- ◯ Prolapse Surgery
- ◯ Rectal Prolapse
- ◯ Skin Grafts
- ◯ Spleen Surgery
- ◯ Tubal Ligation
- ◯ Tubal Ligation Reversal
- ◯ Varicose Vein Surgery
- ◯ Vulvar Surgery
- ◯ Other Surgery

## FAMILY MEDICAL HISTORY

**Please indicate which family member(s) have had these illnesses:**

| | Father | Mother | Grandmother *Mother's side* | Grandfather *Mother's side* | Grandmother *Father's side* | Grandfather *Father's side* | Brother | Sister |
|---|---|---|---|---|---|---|---|---|
| **NO SIGNIFICANT HISTORY** | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| **FAMILY HISTORY UNKNOWN** | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Heart Problems | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Alcohol Abuse | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| High Blood Pressure | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Stroke | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Diabetes | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Breast Cancer | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Colon Cancer | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Ovarian Cancer | | ◯ | ◯ | | ◯ | | | ◯ |
| Lung Cancer | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Mental Illness | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Deceased | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

- ◯ Mother, Grandmother, or Sister developed heart disease before the age of 65.
- ◯ Father, Grandfather, or Brother developed heart disease before the age of 55.

Patient name: _____

# Women's History

Please answer every question.

## SOCIAL HISTORY

**Do you feel safe in your home environment?** yes ○ no ○

**Have you ever been physically or sexually assaulted?** yes ○ no ○

**Have you ever been emotionally abused?** yes ○ no ○

**Do you take calcium supplements?** none ○ dairy ○ supplements ○

**Are you a vegetarian?** yes ○ no ○

**Marital status:** married ○ single ○ divorced ○ widowed ○

**Education** (highest level)**:** high school / GED ○ some college ○ 2 year college degree ○ 4 year college degree ○ post graduate education ○

## TOBACCO USE

**Are you exposed to passive** (second hand) **smoke?** yes ○ no ○

**What is your smoking status?** never smoked ○ former smoker ○ current smoker (every day) ○ current smoker (some days) ○ current status unknown ○ unknown if ever smoked ○

*please fold on dotted line*

**At what age did you begin smoking?**

**If you quit smoking, at what age did you quit?**

**How many cigarettes do you currently smoke or did you previously smoke per day?**

10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

**EXAMPLE**

If you started smoking at the age of 21, you would fill in the ovals like this:

10 20 30
1 2 3

## ALCOHOL USE

**How often do you use alcohol?** **Number of times:** never ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7+ ○

**Per:** week ○ month ○ year ○

**What type(s) of alcohol do you drink?** beer ○ wine ○ liquor ○

**How many drinks do you have per occasion?** 1-2 ○ 3-5 ○ 6-9 ○ 10+ ○

**How often do you have more than five drinks per occasion?** never ○ rarely ○ occasionally ○ frequently ○

## STREET / ILLEGAL DRUG USE

none ○ previous ○ current ○ prefer to discuss with physician ○

*please fold on dotted line*

## HIV HIGH RISK BEHAVIOR?

(HIV Risk Factors: IV drug use, More than one sexual partner, Sex with a prostitute, Unprotected sexual contact, Contact with contaminated injection equipment.)

yes ○ no ○ prefer to discuss with physician ○

## HABITS

**Caffeine**

**Type(s) of caffeine:** coffee ○ tea ○ soft drinks ○

**Drinks per day:** occasionally ○ 0 ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

**Exercise**

**Type(s) of exercise:** bicycling ○ running ○ swimming ○ walking ○ aerobics ○ other ○

**Times per week:** occasionally ○ 0 ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

**How often do you wear a seatbelt?** always ○ almost always ○ occasionally ○ never ○

**Sun exposure:** frequently ○ occasionally ○ rarely ○