Do not write, stamp, punch holes or affix a sticker in this area. To reproduce, follow the printing instructions.

Direction of Feed

Women's History

Please answer every question

*Handwritten items must be entered **MANUALLY**.*

Marking Instructions

Please use a #2 pencil.
Fill in the 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:

BLOOD
- DVT (Deep Vein Thrombosis)
- Anemia
- Sickle Cell Anemia
- Pulmonary Embolism

OTHER: _____

BONE / JOINT
- Osteoarthritis (joint disease)
- Osteopenia
- Osteoporosis
- Rheumatoid Arthritis

CANCER
- Brain
- Breast
- Cervical
- Colon
- Lung
- Ovarian
- Skin
- Thyroid
- Uterine
- Vulva / Perineum

OTHER: _____

DIGESTIVE
- Crohn's Disease
- Gallstones
- Hepatitis
- Irritable Bowel Syndrome (IBS)
- Ulcerative Colitis

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

HEART
- Cardiomyopathy
- Coronary Artery Disease
- Heart Attack
- Heart Murmur
- High Cholesterol
- High Blood Pressure
- Stroke

KIDNEY / BLADDER
- Chronic Blood in Urine
- Interstitial Cystitis
- Kidney Stones

INFECTIONS
- Hepatitis
- AIDS
- Oral Herpes (cold sores)
- Genital Herpes
- HIV Infection (no symptoms)
- MRSA (treatment completed)
- Tuberculosis

MENTAL HEALTH
- Anxiety Disorder
- Depression
- Postpartum Depression
- Post-Traumatic Stress Disorder

NEUROLOGICAL
- Migraines
- Multiple Sclerosis (MS)
- Muscular Dystrophy
- Parkinson's
- Seizures

RESPIRATORY
- Asthma
- COPD
- Emphysema
- Pulmonary Edema
- Pulmonary Embolism
- Sleep Apnea

THYROID
- Goiter
- Grave's Disease
- Overactive Thyroid
- Underactive Thyroid
- Thyroid Nodule

OTHER
_____
_____
_____

NO SIGNIFICANT MEDICAL HISTORY

SURGICAL HISTORY

Please mark all surgeries you have had:

BREAST
- Breast Augmentation
- Breast Lumpectomy
- Breast Reconstruction
- Breast Reduction
- Breast Removal (mastectomy)

HEART
- Cardiac Bypass
- Cardiac Valve Replacement
- Pacemaker

GASTROINTESTINAL
- Appendectomy
- Colon Resection
- Colostomy
- Gallbladder Removal
- Gastric Bypass / Lap Band
- Hernia Surgery

GYNECOLOGICAL
- C-Section
- D&C (dilation & curettage)
- Endometrial Ablation
- Endometriosis Surgery
- Fallopian Tube / Ovary Removal
- Fibroid Removal
- Hysterectomy
- Ovarian Cyst (drain / removal)
- Prolapse Surgery (bladder lift)
- Tubal Ligation
- Tubal Ligation Reversal
- Vulvar Surgery

ORTHOPEDIC
- Back / Spine Surgery
- Joint Replacement (specify joint): _____

I HAVE HAD NO SURGERIES

NEUROLOGICAL
- Brain / Head Surgery
- Cervical Disc
- Lumbar Disc
- Lumbar Laminectomy
- VP Shunt

NOT IN LIST
_____
_____
_____
_____
_____

*For technical support, please contact PatientLink at **Support@MyPatientLink.com.***

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Direction of Feed

Women's History

Please answer every question

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ALLERGIES

Please mark any of the following that apply:

- Latex Allergy
- **NO LATEX ALLERGY**
- **NO KNOWN DRUG ALLERGIES**
- Penicillin
- Sulfa Medications
- Betadine
- Peanuts
- **OTHER:** _____

FAMILY MEDICAL HISTORY

NO SIGNIFICANT HISTORY **FAMILY HISTORY UNKNOWN**

Please indicate which family members have had these illnesses:	Father	Mother	Grandmother *Mother's side*	Grandfather *Mother's side*	Grandmother *Father's side*	Grandfather *Father's side*	Brother	Sister
Heart Problems	○	○	○	○	○	○	○	○
High Blood Pressure	○	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○	○
Alcohol Abuse	○	○	○	○	○	○	○	○
Stroke	○	○	○	○	○	○	○	○
Mental Illness	○	○	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○	○	○
Ovarian Cancer		○	○		○			○
Colon Cancer	○	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○	○
Lung Cancer	○	○	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○	○	○
Prostate Cancer	○			○		○	○	
Skin Cancer	○	○	○	○	○	○	○	○
Uterine Cancer		○	○		○			○
Other Cancer: _____	○	○	○	○	○	○	○	○
Thyroid Condition	○	○	○	○	○	○	○	○
Malignant Hyperthermia	○	○	○	○	○	○	○	○

SOCIAL HISTORY

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

Marital status: ○ married ○ single ○ divorced ○ widowed

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

TOBACCO USE

What is your smoking status? ○ never smoked ○ former smoker ○ current smoker ○ current status unknown ○ unknown if ever smoked

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

DRUG USE

Street / Illegal Drug Use: ○ none ○ previous ○ current

HABITS

Do you get calcium? ○ none ○ dairy ○ supplements

Caffeine drinks per day (8 oz = 1 drink): ○ 0 ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+

Exercise times per week: ○ 0 ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+