

# 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  YES  NO Discontinued for what reason? \_\_\_\_\_
- Barrier methods  YES  NO Discontinued for what reason? \_\_\_\_\_  
(condoms, spermicides, diaphragm)
- Depo-Provera  YES  NO Discontinued for what reason? \_\_\_\_\_
- Norplant  YES  NO Discontinued for what reason? \_\_\_\_\_
- Permanent Sterilization  YES  NO  
(tubal ligation, vasectomy)
- IUD  YES  NO Discontinued for what reason? \_\_\_\_\_
- Rhythm  YES  NO Discontinued for what reason? \_\_\_\_\_  
(Periodic abstinence)
- Withdrawal  YES  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? \_\_\_\_\_
- 51. Did you use any fertility drugs? \_\_\_\_\_
- 52. Have you ever had a "molar pregnancy"? \_\_\_\_\_
- 53. Did you have any complications of pregnancy, labor, delivery or post-partum? \_\_\_\_\_

**Were you ever told you had:**

- 54. Insulin dependent Gestational diabetes? \_\_\_\_\_
- 55. Pre-eclampsia/Eclampsia? \_\_\_\_\_
- 56. Post-Partum Hemorrhage? \_\_\_\_\_
- 57. Extensive Cervical or Vaginal Lacerations? \_\_\_\_\_

**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"/>

