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

		YES	NO
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 _______		
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:

Method			
Birth control pills	❑ YES	❑ NO	Discontinued for what reason? ______________
Barrier methods (condoms, spermicides, diaphragm)	❑ YES	❑ NO	Discontinued for what reason? ______________
Depo-Provera	❑ YES	❑ NO	Discontinued for what reason? ______________
Norplant	❑ YES	❑ NO	Discontinued for what reason? ______________
Permanent Sterilization (tubal ligation, vasectomy)	❑ YES	❑ NO	
IUD	❑ YES	❑ NO	Discontinued for what reason? ______________
Rhythm (Periodic abstinence)	❑ YES	❑ NO	Discontinued for what reason? ______________
Withdrawal	❑ YES	❑ NO	Discontinued for what reason? ______________

MENOPAUSE

		YES	NO
14.	Approximate age of menopause _______ Natural _______ Surgical _______		
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? ____________________	❑	❑
33. Do you have spotting/bleeding after intercourse? ____________________	❑	❑
34. Do you have pain with intercourse? ____________________	❑	❑
35. Do you have any problems with intercourse you wish to discuss? ____________________	❑	❑
36. Do you have any unusual vaginal discharge? ____________________	❑	❑
37. Do you have any vaginal odor? ____________________	❑	❑
38. Do you have external or internal itching/burning? ____________________	❑	❑
39. Do you have any lumps in your breasts? ____________________	❑	❑
40. Do you have nipple discharge when not breast feeding? ____________________	❑	❑
41. Do you have chronic pelvic pain? ____________________	❑	❑
42. Do you have any bladder problems? ____________________	❑	❑
43. Do you have any bowel problems? ____________________	❑	❑

OBSTETRICAL HISTORY:

44. Do you think you are pregnant? ____________________ ❑ ❑
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? ____________________ ❑ ❑
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:

		YES	NO
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?	YES	NO
58.	Breast Cancer	____	________	❑	❑
59.	Uterine Cancer	____	________	❑	❑
60.	Cervical Cancer	____	________	❑	❑
61.	Ovarian Cancer	____	________	❑	❑
62.	Colorectal Cancer	____	________	❑	❑
63.	Other Cancer	____	________	❑	❑
64.	Diabetes	____	________	❑	❑
65.	High Blood Pressure	____	________	❑	❑
66.	Heart Disease	____	________	❑	❑
67.	Stroke / Alzheimer's Disease	____	________	❑	❑
68.	Lung Disease	____	________	❑	❑
69.	Kidney Disease	____	________	❑	❑
70.	Liver/Gallbladder Disease	____	________	❑	❑
71.	Thyroid Disease	____	________	❑	❑
72.	Gastrointestinal Disease	____	________	❑	❑
73.	Bone/Joint Disease	____	________	❑	❑
74.	Blood Disease/Anemia	____	________	❑	❑
75.	Seizure Disorder	____	________	❑	❑
76.	Headaches-Migraine or tension	____	________	❑	❑
77.	Psychiatric Illness	____	________	❑	❑
78.	Human Immunodeficiency Virus (AIDS)	____	________	❑	❑
	Other	____	________	❑	❑
		____	________	❑	❑

		YES	NO
79.	Have you ever had a blood transfusion? ________	❑	❑
	What reason? ________ How many units ____		
80.	Do you have a heart murmur? ________	❑	❑
81.	Do you take antibiotics prior to dental procedures? ________	❑	❑
82.	Do you have a pacemaker? ________	❑	❑
83.	Do you have an irregular heart rate or rhythm? ________	❑	❑
84.	Do you have any skin diseases? ________	❑	❑
85.	Have you been hospitalized for anything else not previously discussed? ________	❑	❑
86.	Who is your primary physician? ________	❑	❑

PAST SURGICAL HISTORY:

Have you had any of these operations?		Date	Surgeon	YES	NO
87.	Abdominal or Vaginal Hysterectomy	____	________	❑	❑
88.	Removal of Tubes and Ovaries	____	________	❑	❑
89.	Bilateral Tubal Ligation (tubes tied, cut, burned)	____	________	❑	❑
90.	Bladder Surgery	____	________	❑	❑
91.	Cervical Cone Biopsy/Cryosurgery/Leep	____	________	❑	❑
92.	Laser surgery of Vulva/Vagina/Cervix	____	________	❑	❑
93.	Exploratory Laparotomy (abdominal surgery)	____	________	❑	❑
94.	Mastectomy Right, Left or Both (breast removed)	____	________	❑	❑
95.	Breast Biopsy Right, Left or Both	____	________	❑	❑

	Date	Surgeon	YES	NO
96. Breast Reduction or Augmentation	______	______	❑	❑
97. Appendectomy (appendix removed)	______	______	❑	❑
98. Cholecystectomy (gall bladder removed)	______	______	❑	❑
99. Thyroidectomy (thyroid removed)	______	______	❑	❑
100. Bowel Resection (large or small bowel)	______	______	❑	❑
101. Heart Surgery	______	______	❑	❑
102. Tonsils or Adenoids Removed	______	______	❑	❑
103. Hernia Surgery	______	______	❑	❑
Other	______	______	❑	❑
	______	______		
	______	______		

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? ______	❑	❑
107. Have you in the past? ______	❑	❑
108. How many cigarettes per day _____? How many years all together? ______	❑	❑
109. Do you drink alcohol? ______	❑	❑
110. Have you in the past? ______	❑	❑
111. How many ounces per week _____? How many years? ______	❑	❑
112. Do you drink caffeinated beverages (coffee, tea, sodas)? ______	❑	❑
113. On an average day, how many cups/glasses do you consume? ______	❑	❑
114. Do you now, or have you in the past ever used any recreational drugs or abused prescription drugs? _	❑	❑
115. Do you exercise regularly? ______	❑	❑

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

116. Mammogram ______	❑	❑
117. Breast Ultrasound ______	❑	❑
118. Pelvic Ultrasound ______	❑	❑
119. Sigmoidoscopy ______	❑	❑
120. Barium Enema ______	❑	❑
121. Upper GI ______	❑	❑
122. Colonoscopy ______	❑	❑
123. Stool check for blood ______	❑	❑
124. Laboratory work of any kind ______	❑	❑

REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms?

Constitutional:		**Integument:**	
	Fever		Rashes
	Chills		Changes to existing lesions / moles
	Body Aches		
	Night Sweats	**Neurologic:**	
	Loss of Appetite		Muscular weakness
	Weight Gain		Incoordination
	Weight Loss		Tingling or numbness
	Weakness / Fatigue	**Musculoskeletal:**	
			Joint pain
Eyes:			Muscle pain
	Discharge from Eye		Back pain
	Impaired Vision / Change in Vision		
HENT:			
	Headaches		
	Nasal Congestion		
	Neck Stiffness	**Endocrine:**	
Breasts:			Excessive urine production (Polyuria)
	Lumps		Excessive thirst (Polydipsia)
	Tenderness		Cold intolerance
	Swelling		Heat intolerance
	Nipple Discharge	**Psychiatric:**	
Cardiovascular:			Anxiety
	Chest pain		Depression
	Syncope (Fainting)		Confusion
	Severe shortness of Breath with Exertion		Insomnia
			Excessive anger
			Mood Swings
		Heme-Lymph:	
Respiratory:			Easy bleeding
	Shortness of Breath		Easy bruising
	Cough		Lymph node enlargement or tenderness
		Allergic-Immunologic:	
Gastrointestinal:			Sinus / allergy symptoms
	Nausea, Vomiting		Frequent illnesses
	Diarrhea		
	Constipation		
	Blood in Stools		
Genitourinany:			
	Urinary urgency		
	Urinary frequency		
	Painful urination		
	Urinary incontinence		
	Waking up more than once per night to urinate		

Thank you for taking the time to answer these questions. Most insurance companies now require this information to be updated at every visit.