Women's Health History W_____

1. Reason for your visit.
   □ Recheck _____ □ Pap smear □Discharge □ Birth Control
   □ STD testing/exposure/symptoms □ Other _____
2. Pap Smear History: First Pap □ Yes □ No, Date of last _____
   □ Normal □ Abnormal Ever had an abnormal pap □ No □ Yes
3. Menstrual History: Age of 1st menstrual period _____
   Date of last menstrual period _____ □ Regular □ Irregular
   Describe any changes in menstrual period _____
   # of pregnancies _____ # of births _____
   Pregnant now □No □Yes Breast feeding □No □Yes
4. Breast History:
   □ Do you perform breast self-exams □ No □ Yes □ Monthly □ Occasionally
   □ Breast changes? □ Lump □ Pain □ Tender □ Discharge
5. Vaginal History: Check all symptoms you are currently experiencing.
   □ Discharge: color _____, How long_____ □ odor
   □ Pain: Location _____ □ Bleeding □ itching
   □ Burning with urination □ Burning, Other _____
   □ Sore or lesions? _____
   □ Have you had 3 HPV Vaccines □No □Yes
6. Sexual History:
   Have you ever had sex? □ No □ Yes Age began? _____ Last sex_____
   Number of partners? Last 3 months?_____ Lifetime? _____
   Sexual preference: □ Male □ Female □ Both
   Site Preference: □ Oral □ Anal □ Vaginal
   Birth control method/s? _____
   Condom usage: □ Always □ Usually □ Sometimes □Never
   Have you ever had a sexually transmitted disease? □ No □ Yes _____
7. Do you have any drug allergies □ No □ Yes List drug and reaction
   _____
8. Do you have any food or other allergies □ No □ Yes List and describe the reaction _____
9. Current Medications

Name	Dosage	Reason Prescribed

10. Caffeine use: □ Never □< 2/day □> 2/day □> 2/week □ >2/month
    How long? _____ Type: □ Coffee □ Soda □ Energy drinks
11. Tobacco Use: □ Never □ Yes, complete information below.
    □ Cigarettes □Never □< 1/2 pk/day □> 1/2 pk/day
    □ 1 pk/day □>1 pk/day How Long?_____
    □ Other : Type_____ Amt_____ How long? _____
12. Alcohol Use: □ Never □< 2/day □> 2/day □> 2/week □ >2/month
    How long? _____ Type: □ Beer □ Liquor □ Both
13. Illegal drugs: □ Never □< 2/day □> 2/day □> 2/week □ >2/month
    How long? _____ Type: _____
14. Medical History Circle any current medical problems you have. Record date or year of diagnosis.

Anemia		Mental problems
Asthma	Epilepsy	Migraine Headaches
Bleeding disorder	Heart murmur	Physical limitations
Cancer	Heart problems	Rheumatic Fever
Cerebral Palsy	Hepatitis	Arthritis
Colitis	High blood pressure	Scoliosis
Congenital Defect	Irritable bowel	Thyroid problems
Cystic Fibrosis	Kidney stone	Tuberculosis
Diabetes	Medical disability	Pos TB skin test

    Other: _____
15. List any surgeries with dates: _____
16. List any recent hospitalizations, reason & date:_____
17. Family History: Complete if this is your first visit. List family member affected. Has anyone in your immediate family (parents, siblings, grandparents) had a history of any of the following?
    □ Thyroid problems _____ □ Alzheimer's/Dementia _____
    □ Anemia-Sickle cell _____ □ Asthma/Respiratory _____
    □ Bleeding problems _____ □ Cancer _____
    □ Diabetes _____ □ Tuberculosis _____
    □ Heart Disease _____ □ High blood pressure _____
    □ Mental/emotional problems ___ □ Stroke _____
18. Is your Mother living □ Yes □ No Is your Father living □ Yes □ No
19. Over the last 2 weeks, how often have you been bothered by:
    a. Feeling nervous, anxious or on edge?
       □ Not at all □ Several Days □ More than ½ the Days □ Nearly Every Day
    b. Not being able to stop or control my worrying?
       □ Not at all □ Several Days □ More than ½ the Days □ Nearly Every Day
20. During the past month, have you been bother by:
    a. Little interest or pleasure in doing things?
       □ Not at all □ Several Days □ More than ½ the Days □ Nearly Every Day
    b. Feeling down, depressed or hopeless?
       □ Not at all □ Several Days □ More than ½ the Days □ Nearly Every Day