Women's Health Care Health History Intake Form

Allergies : ◯ **NKA** ◯ **Other**:_____
Name:_____

Medications: _____ **DOB:** _____

Pharmacy: _____

Past Medical History (mark all that apply):

Abnormal Pap	◯	**Diabetes**	◯	**Lupus**	◯
Abnormal bleeding	◯	**Deep vein blood clot**	◯	**Osteoporosis**	◯
No menses	◯	**Painful periods**	◯	**Ovarian cyst**	◯
Anemia	◯	**Painful sex**	◯	**PCOS**	◯
Anxiety	◯	**Endometriosis**	◯	**PID**	◯
Asthma	◯	**Fibroids**	◯	**Rheumatoid arthritis**	◯
Blood transfusion	◯	**Genital warts**	◯	**Spina Bifida**	◯
Breast problems	◯	**Heart murmur**	◯	**Sexually transinfections**	◯
Cancer	◯	**HIV/AIDS**	◯	**Stroke**	◯
Chronic pain	◯	**Hormone problem**	◯	**Substance abuse**	◯
Clotting disorder	◯	**High blood pressure**	◯	**Thyroid disease**	◯
Heart disease	◯	**Infertility**	◯	**Trauma/violence**	◯
Depression	◯	**Kidney disease**	◯	**Urinary incontinence**	◯
DES exposure	◯	**Liver disease**	◯	**Uterine anomaly**	◯
Other	◯				

Surgical history:

Abdominal surgery	◯	**Cystocele/rectocele repair**	◯	**Hysteroscopy**	◯
Appendectomy	◯	**Colposcopy**	◯	**Laser conization**	◯
Bladder suspension	◯	**Cosmetic surgery**	◯	**LEEP**	◯
Breast enlargement	◯	**D&C**	◯	**Oophorectomy**	◯
Breast surgery	◯	**Endometrial ablation**	◯	**Laparoscopy**	◯
Cesarean	◯	**GYN cryosurgery**	◯	**Tubal ligation**	◯
Colon surgery	◯	**Hysterectomy**	◯	**Other**	◯

Menstrual history:

Age at first menstrual period: _____ **Menstrual cycle every** _____
Last menstrual period:_____ **Duration:** _____
Menstrual pattern: **Regular** ◯ **Irregular** ◯
Flow: **Light** ◯ **Moderate** ◯ **Heavy** ◯ **Clots** ◯

Type of sanitary protection:

Panty liner	◯
Thin pad	◯
Maxi pad	◯
Hospital pad	◯
Tampon	◯
Tampon and pad	◯
Other	◯

Change pad/protection every _____

Pain with menstrual cycle:

None	◯
Mild	◯
Moderate	◯
Severe	◯

Family History:

	Mark if deceased	Breast cancer	Colon cancer	Ovarian cancer	Diabetes	Heart disease	High cholesterol	High blood pressure	Deep vein clot	Migraines	Lupus	Rheumatoid disease	Osteoporosis	Seizures	Stroke	Thyroid disease	Other
Patient																	
Mother																	
Father																	
Brother																	
Sister																	
Paternal grandmother																	
Paternal grandfather																	
Maternal grandmother																	
Maternal grandfather																	
Paternal aunt																	
Paternal uncle																	
Maternal aunt																	
Maternal uncle																	

Obstetrical History:

Total number of pregnancies: _____ Number of term deliveries: _____ Number of preterm deliveries: _____ Number of miscarriages: _____

Number of abortions: _____ Number of twin pregnancies: _____ Number of living children: _____ Number of ectopic/tubal pregnancies: _____

Date of birth	Gestational age	Birth weight	Sex	Baby's name	Type of delivery	Anesthesia	Mark if preterm labor	Mark if living	Place of birth	Length of labor

Social history:

Tobacco use:
- Never user ◯
- Everyday user ◯
- Someday user ◯
- Former user ◯
- Heavy user ◯
- Light user ◯
- Passive exposure ◯

If yes, number of packs per day: _____

Alcohol use: Yes ◯ No ◯

_____ glasses of wine per week
_____ beers per week
_____shots per week
_____mixed drinks per week

Drug use: Type:_____
Number of times per week:_____

Sexually active: Yes ◯ No ◯
_____number of partners in last year
Male ◯ Female ◯

Birth control method:

Abstinence	◯	IUD	◯
Withdrawal	◯	Pills	◯
Condoms	◯	Patch	◯
Diaphragm	◯	Natural family planning	◯
Implant/Nexplanon	◯	Spermicide	◯
DepoProvera	◯	Sponge	◯
Inserts	◯	Tubal/vasectomy	◯

Mark if yes:

- On a special diet ◯
- Lost >5-10 lbs unintentionally ◯
- Difficulty swallowing ◯
- Refuse blood transfusions ◯
- Homeless/housing problems ◯
- In drug/alcohol treatment ◯
- Domestic violence/abuse ◯
- Feel would be better off dead ◯
- Need help walking ◯
- Transportation problems ◯
- Separated from father of baby ◯
- History of forced sex/coercion ◯
- Thoughts of self- harm ◯
- Live alone ◯
- Fallen in the past year ◯
- History of abuse/violence ◯
- Recent death of loved one ◯

Occupation: _____

Partner/spouse name:_____