

Name

Age

Date of Birth

Date

FEMALE MEDICAL HISTORY

This information is confidential and will be used by your medical provider to make sure you get proper care.

- Yes No Are you allergic to any medications? List here: _____
- Yes No Do you take any over the counter medicines, prescription medicines, vitamins, supplements, or home remedies? List here: _____
- Yes No Do you have a usual source of primary care? If yes, who? _____

A. Family Medical History:

Has anyone in your family (mother, father, brother, sister) ever had:

- | | | |
|--|--|--|
| 1. <input type="checkbox"/> Heart attack/disease | 6. <input type="checkbox"/> Diabetes | 10. <input type="checkbox"/> Maternal DES exposure |
| 2. <input type="checkbox"/> Stroke | 7. <input type="checkbox"/> Alcohol or drug abuse | 11. <input type="checkbox"/> Cancer |
| 3. <input type="checkbox"/> Blood clot in legs/lungs | 8. <input type="checkbox"/> Birth defects/genetic problems | 12. <input type="checkbox"/> I do not know my family medical history |
| 4. <input type="checkbox"/> High blood pressure | 9. <input type="checkbox"/> Mental illness | |
| 5. <input type="checkbox"/> High cholesterol | | |

B. Personal Medical History:

1. Have YOU ever had problems with any of these? Check all that apply.

- | | | |
|--|---|--|
| A. <input type="checkbox"/> Heart disease | K. <input type="checkbox"/> Sickle cell disease | S. <input type="checkbox"/> Gall bladder disease |
| B. <input type="checkbox"/> High blood pressure | L. <input type="checkbox"/> Kidney/bladder problems | T. <input type="checkbox"/> Eating disorder |
| C. <input type="checkbox"/> Stroke | M. <input type="checkbox"/> Seizures or epilepsy | U. <input type="checkbox"/> Cancer |
| D. <input type="checkbox"/> Diabetes | N. <input type="checkbox"/> Depression | Type: _____ |
| E. <input type="checkbox"/> High cholesterol | O. <input type="checkbox"/> Suicidal thoughts | V. <input type="checkbox"/> Thyroid disease |
| F. <input type="checkbox"/> Tuberculosis (TB) | P. <input type="checkbox"/> Mental illness | W. <input type="checkbox"/> Fibroids |
| G. <input type="checkbox"/> Asthma | Q. <input type="checkbox"/> Severe headaches or migraines | X. <input type="checkbox"/> Ovarian cyst/abnormality |
| H. <input type="checkbox"/> Blood clot in legs/lungs | R. <input type="checkbox"/> Liver problems or hepatitis | Y. <input type="checkbox"/> Endometriosis |
| I. <input type="checkbox"/> Bleed/bruise easily | | Z. <input type="checkbox"/> Infertility |
| J. <input type="checkbox"/> Anemia | | |

2. Yes No Have you ever been hospitalized or had any surgery? If yes, when and why? _____
3. Yes No Have you ever had a transfusion or blood exposure?
4. Yes No Have you been immunized against rubella? I do not know
5. Yes No Have you been immunized against hepatitis B? I do not know
6. When was your last Pap smear? _____ I never had a Pap smear
- Yes No Have you ever had an abnormal Pap smear? If yes, when? _____
7. Yes No Have you ever had an HIV test? If yes, when was your last one? _____ Was it: Positive Negative?
8. Yes No Have you ever had a mammogram? If yes, when was your last one? _____ Was it normal? _____

C. Menstrual History:

1. Age period started: _____
2. Periods come every _____ days and last _____ days.
3. Periods are: Regular Irregular Painful Light Moderate Heavy
4. Yes No Do you have bleeding or spotting in between your periods?

D. Pregnancy History: (If you have never been pregnant, skip to next section)

1. Please list the number of the following: _____ Pregnancies _____ Live births _____ Abortions _____ Miscarriages _____ Ectopic (tubal) pregnancies
2. How long ago was your last pregnancy? _____ month(s), _____ year(s)
3. Yes No Are you currently breastfeeding?

Provider notes:



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E. Contraception History:

Provider notes:

1. How old were you when you first had vaginal intercourse? _____ years old I never had sex
2. How important is it for you to avoid pregnancy now? Very Somewhat Not at all
3. What birth control methods have you used in the past? None

A. <input type="checkbox"/> Condoms/rubbers	F. <input type="checkbox"/> IUD	J. <input type="checkbox"/> Foam/film or jelly
B. <input type="checkbox"/> Birth control pills	G. <input type="checkbox"/> Implants under the skin	K. <input type="checkbox"/> Withdrawal/pulling out
C. <input type="checkbox"/> DepoProvera/shot	H. <input type="checkbox"/> Diaphragm/cervical cap	L. <input type="checkbox"/> Rhythm method
D. <input type="checkbox"/> Patch	I. <input type="checkbox"/> Tubal ligation/tubes tied	M. <input type="checkbox"/> Partner has vasectomy
E. <input type="checkbox"/> NuvaRing (vaginal ring)		
4. What birth control are you and your partner(s) currently using? _____ None
5. Yes No Are you happy with your method?
6. How often do you use condoms? Always Sometimes Never
7. Yes No Have you ever used emergency contraception (morning after pill/Plan B)?
8. Yes No Maybe Are you planning to get pregnant in the next two years?

F. Habit and Lifestyle:

- If you prefer, you can talk to your health care provider about these important questions.
1. How many glasses of an alcoholic beverage do you have per week? _____ None
 2. Yes No Do you smoke cigarettes? If yes, how many cigarettes per day? _____
 3. Yes No Do you use street drugs? If yes, please list: _____
 4. Yes No Have you ever used injected drugs?
 5. Yes No Have you ever shared needles?
 6. Yes No Has anyone ever told you that you have a problem with drugs or alcohol?
 7. Yes No Is anyone, including your partner, threatening you, causing you to be afraid, or hurting you physically?
 8. Yes No Have you ever been pressured or forced to have sex when you did not want to?
 9. Have you ever had a sex partner with a history of: Injected drug use Sex with men HIV

G. Sexual History:

- In the last 12 months...**
1. Yes No Have you been sexually active? If no, skip to #6.
If yes, how many sexual partners have you had? _____
 2. Have you had sex with: Men Women Both?
 3. Have you and/or your partner(s) had: Oral sex Anal sex Vaginal sex?
 4. Yes No Have you traded sex for money or drugs?
 5. Do you think that your partner has other sexual partners?
 Yes, definitely Not sure, possibly No, very unlikely
 6. In the last 12 months have you or your sex partner(s) had any of the following:

A. <input type="checkbox"/> Chlamydia	D. <input type="checkbox"/> Trichomoniasis (Trich)	G. <input type="checkbox"/> Bacterial vaginosis (BV)
B. <input type="checkbox"/> Gonorrhea	E. <input type="checkbox"/> Pelvic Inflammatory Disease	H. <input type="checkbox"/> Syphilis
C. <input type="checkbox"/> Genital Herpes	F. <input type="checkbox"/> Genital warts	I. <input type="checkbox"/> Other: _____
 7. Yes No Is there anything else about your health or sexual practices that you would like to discuss with your clinician?

Patient Signature/Date

Clinician Signature/Date

Clinician Signature/Date Updated

Clinician Signature/Date Updated



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