

History

If you do not understand a question, please leave it blank

(All Information is Regarded as Confidential)

Name (Last)	(First)	Birth Date			Date	Client No.	Master Record #
		Mo	Day	Yr	____/____/____	____	____

ALLERGY HISTORY

Are you allergic to anything? (Medications, food, insects, environmental) No
 If yes, list allergy and reaction

MEDICATION HISTORY

Do you take any prescription or over-the-counter medications? No
 If yes, list medications (include birth control pills and vitamins, hormone replacement therapy, herbs)

IMMUNIZATION HISTORY

Have you ever had or been vaccinated for:

	Yes	Year
Chicken Pox.....	<input type="checkbox"/>	_____
Hepatitis B (3 shots).....	<input type="checkbox"/>	_____
Rubella (German Measles).....	<input type="checkbox"/>	_____

SURGERIES / HOSPITALIZATIONS NA

(List the most recent first) If more than three (3) check here

<u>Reason/Diagnosis/Procedure/Blood Transfusion</u>	<u>Year</u>
1. _____	_____
2. _____	_____
3. _____	_____

GYNECOLOGICAL / MENSTRUAL HISTORY

(Describe menstrual periods without a birth control method)

Age at first menstruation? _____

Have you ever had a vaginal or internal pelvic exam? Yes No

Have you ever had a pap smear? Yes No
 If yes, was it ever abnormal? Yes No
 When was your last pap test? _____

If you are postmenopausal, skip to the *

Number of days of menstrual flow? 1-3 4-6 7-8 9+
 Amount of flow? Light Medium Heavy
 How many pads/tampons used in 24 hours? _____

How many days between the start of one period and the start of the next?
Less than 25 26-28 29-32 32+

Do you have painful menstruation (cramps)? Yes No
 If yes, are the cramps Mild Moderate Severe

Do you have any bleeding between periods? Yes No

*If you are postmenopausal, were your periods regular before age 40? Yes No

*Have you had any spotting since menopause? Yes No

FAMILY HISTORY

Are you adopted? Yes No
 Does anyone in your immediate biological family (parents, grandparents, brother/sister) have or ever had:

	Yes	Relative
Diabetes.....	_____	_____
Cancer (ovarian, breast, colorectal).....	_____	_____
High blood pressure.....	_____	_____
Stroke.....	_____	_____
Heart attack before age 50.....	_____	_____
Blood disorders.....	_____	_____
Heart disease/high cholesterol.....	_____	_____
Blood clots in legs.....	_____	_____
Did your mother take DES (Diethylstilbestrol) while pregnant with you?.....	_____	_____

MEDICAL HISTORY

Do you now, or have you ever had (check the appropriate boxes)

	Yes	No	Age
Severe or frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness or fainting (falling out)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy (seizures/fits)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression, mania or bipolar	<input type="checkbox"/>	<input type="checkbox"/>	_____
Schizophrenia or other disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease, murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Leg pain, swelling, redness, blood clot	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of breath/lung disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver disease (hepatitis, yellow jaundice)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast lump/discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes (sugar)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia (low blood)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anorexia/Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Physical disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	_____

PREGNANCY HISTORY

Have you ever been pregnant, had a miscarriage or an abortion? Yes No

Pregnancies _____ # Miscarriages _____
 # Premature Babies _____ # Abortions _____
 # Living Children _____ # Ectopics _____

<u>Born-Mo/Yr.</u>	<u>Wks Preg.</u>	<u>Wt.</u>	<u>Sex</u>	<u>Del Type</u>	<u>Remarks</u>
1. _____					
2. _____					
3. _____					
4. _____					

Have you ever been depressed after delivery? Yes No

Did you breastfeed? Yes No

CONTRACEPTIVE HISTORY

(Please check all methods that you've ever tried)

- Abstinence (not having sex)
 CM/BBT (natural/rhythm)
 Condoms (rubbers)
 Cream/jelly/film/foam/suppositories
 Depo-Provera (the shot)
 Diaphragm
 IUD
 Norplant
 Oral Contraceptives (pills)
 Hysterectomy
 Tubal ligation
 Male vasectomy

If you don't use that method anymore, why did you stop?

Are you using birth control now? Yes [] No []
If yes, what? _____
If no, do you want a method of birth control? Yes [] No []

STD HISTORY

Do you now or have you ever had:

(Please check the appropriate boxes and put the date of the most recent episode)

Table with columns: Yes, No, Mo/Yr. Rows include Chlamydia, Warts, Gonorrhea, Herpes, PID, Syphilis, and other vaginal infections.

Client Signature _____

EXAMINER'S COMMENTS:

Examiner Signature _____

HISTORY UPDATE:

Examiner Signature _____

If you are uncomfortable or if you are unable to answer a question, you may leave it blank.

SOCIAL / SEXUAL HISTORY

- Do you usually wear a seatbelt? Yes [] No []
Do you smoke cigarettes? Yes [] No []
Do you drink beverages or eat foods with caffeine? Yes [] No []
Do you drink alcohol (wine, wine cooler, beer, liquor)? Yes [] No []
Have you ever had sex? Yes [] No []
Do you have pain during or after sex? Yes [] No []
Do you bleed during or after sex? Yes [] No []
Are your partners Male [] Female [] Both []
Has your partner had sex with other people? Yes [] No []
Has your partner or a family member or friend ever threatened you or tried to physically hurt you? Yes [] No []
Have you ever been forced to have sex? Yes [] No []
Have you engaged in risky behavior such as having sex while you or your partner are drunk or high on drugs? Yes [] No []
Have you had sex without protection since your last period? Yes [] No []
Have you changed partners in the last 6 months? Yes [] No []
Do you use condoms? Always [] Sometimes [] Never []

Date _____

Date _____

Current Medications

Date _____