St. Charles Center for Women's Health

HEALTH HISTORY FORM

Name: _____ Age_____ Birthday: _____
Home Phone: _____ Work Phone: _____
Primary Physician: _____ Physician that sent you: _____
Reason for visit today: _____
_____

Medication:	Dose:	Allergies:	Reaction:

Gynecologic History

Age when menses started _____ First day of last menstrual period _____
How many days does it last: _____
Period occurs every <21 days: ___21-30 days:___30-35 days___>35 days___
Do you have menstrual cramps/pain?: ___ How severe?: Mild___ Moderate___ Severe_____
Do you ever bleed between periods?:_____ After intercourse?: _____ Since Menopause?: _____
What do you use for contraception: _____
Have you ever had:

☐ Fibroids	☐ Genital Herpes	☐ Bacteria Vaginosis
☐ Endometriosis	☐ Gonorrhea	☐ Yeast Infection
☐ Ovarian Cysts	☐ Chlamydia	☐ Hot Flashes
☐ Endometrial Polyps	☐ Genital Warts	☐ Vaginal Dryness/itching
☐ Pelvic Inflammatory Disease	☐ Syphilis	☐ Mood Swings

Have you gone through menopause: No____ Yes____ What age? _____
Have you used Hormone replacement: No____ Yes____ How many years:_____
Date of last pap smear: _____ Normal?: Yes____ No ____
Have you ever had an abnormal pap smear?: Yes____ No ____ Did you have:☐Cyro☐Colpo☐LEEP☐Cone
Date of last mammogram: _____Normal?: Yes____ No ____ Self breast exam Yes___No___

Sexual history:

Are you sexually active?: Yes____ No ____ Do you ever have pain with intercourse?: Yes____ No_____
Is your sex life satisfactory?: Yes____ No ____ Sexual Preference: Male_____ Female: _____
Any history of physical, emotional or sexual abuse? Yes____ No ____
Lifetime # of sexual partners: _____

Social History:

Smoke: No _____ Yes____ How much:? _____ Number of years:? _____
Drink alcohol: No _____ Yes ____ How much per week?: _____ Seat belt?: Yes____ No ____
Drink beverage with caffeine: Yes ____ No ____ How much per day? _____
Current or history of using street drugs?: No _____ Yes_____ Type: _____ Frequency?: _____
Do you exercise regularly: Yes____ No ____ Describe: _____
Did you serve in the Military? Yes____ No ____

Urinary Problems: Patient Name: _____ DOB: _____

☐ Urine loss with coughing	☐ Pain with urination	☐ Bed wetting
☐ Urine loss with urgency	☐ Blood in urine	☐ Up at night to urinate
☐ Urinary urgency	☐ Bladder infection	(_____times)
☐ Urinary frequency	☐ Difficulty Urinating	☐ Uncontrollable
	☐ Wear urinary incontinence products	

Obstetrical History:

Total number of pregnancies _____ Number of living children _____ Number of miscarriages _____

Ectopic pregnancies _____ Terminations _____ Difficulty getting pregnant _____

Date of delivery	Infant Weight:	Type of delivery Vaginal or C-Section	Date of delivery	Infant weight	Type of delivery Vaginal or C-Section

Do you have to take antibiotics before going to the dentist or having a procedure Yes ____ No ____

When was your last dental appointment?_____

Have you been vaccinated for Pneumonia? Yes _____ No _____

Medical History:

____ Diabetes	____ Anemia	____Cancer
____ High Blood Pressure	____ Bleeding problems	____ Multiple sclerosis
____ Stroke	____ Liver disease	____ Parkinson's
____ Arthritis	____ Osteoporosis	____ Alzheimer's
____ Clotting Disorder/DVT	____ Gall bladder disease	____ Fibromyalgia
____ Tuberculosis	____ Hepatitis (B___/C___)	____ HIV/AIDS
____ Asthma	____ Depression/Anxiety	____ Thyroid
		____ Seizure disorders

Surgical History:

Year	Operation	Hospital

Family History:

____Breast cancer	____ High Blood Pressure	____ Alzheimer's
____Ovarian cancer	____ Heart Disease	____ Alcoholism
____ Uterine cancer	____ Stroke	____ Seizure disorders
____ Colon cancer	_ ___ Parkinson's	____ Psychiatric disorders
	_ ___ Diabetes	____ Clotting Disorder/DVT

Have you recently experienced?

____ Constipation	____Chest pain	____ Weakness/Numbness	____ Diarrhea
____ Heart attack	____ Suicidal thoughts	____ Soiling pants with BM	____ Skin Problems
____ Swollen Glands	____ Blood in stool	____ Abnormal hair growth	____Breast Lumps
____ Vomiting blood	____ Headaches	____ Hoarseness	____Vaginal Issues
____ Change in vision	____ Coughing up blood	____ Sudden weight change (up/down)	
____ Change in hearing	____ Difficulty breathing	____ Appetite change	

Physician signature: _____ Date: _____

Patient signature: _____ Date: _____