Women's Health History Questionnaire

Date:							
Name:	Marital Status: (circle)	S	M	W	D	Sep	Date of Birth:
School/University:	Occupation/Employer:						Referred By:
Reason for Visit:							

PAST MEDICAL/FAMILY HISTORY – Please (✓) check if you (Pers) or any blood relative (Fam) had any of the following conditions.

	Pers	Fam			Pers	Fam	
1. Wt Loss-Gain	☐	☐		14. Kidney Disease	☐	☐	
2. Headaches / Migraine	☐	☐		15. Urinary Infections	☐	☐	
3. Heart Disease	☐	☐		16. Blood Transfusions	☐	☐	
4. Sleep Problems	☐	☐		17. Anemia / Blood Disorder	☐	☐	
5. Rheumatic Disease	☐	☐		18. Acne – Complexion Problem,			
6. High Blood Pressure	☐	☐		Skin Disease, other	☐	☐	
7. High Cholesterol	☐	☐		19. Diabetes	☐	☐	
8. Respiratory (Lung) Disease	☐	☐		20. Thyroid Disease	☐	☐	
9. Breast Disease	☐	☐		21. Cancer (type)	☐	☐	
10. Jaundice / Hepatitis	☐	☐		22. Epilepsy / Seizures	☐	☐	
11. Hiatal Hernia (Reflux)	☐	☐		23. Arthritis – Joint Pain	☐	☐	
12. Peptic Ulcer (Stomach)	☐	☐		24. Anxiety / Depression	☐	☐	
13. Bowel Disease	☐	☐					

HOSPITAL ADMISSIONS – List those operations & serious illnesses which required hospitalization (Excluding Pregnancy)

Year	Reason for Admission / Hospital	Year	Reason for Admission / Hospital

PAST SURGICAL HISTORY

Year	Reason for Surgery	Year	Reason for Surgery

MEDICATIONS – List all medications you are currently taking (dosage – frequency) – Include over the counter drugs

			Drug Allergies

OBSTETRICAL HISTORY Number of Pregnancies ____ Premature Babies ____ Miscarriages ____ Abortions ____ Living Children ____

MENSTRUAL HISTORY

Age at first period? _____ If menstruating – Date of last period (1st day)? _____

Periods are ☐ Regular ☐ Somewhat Irregular ☐ Completely Irregular

Period Interval (1st day to 1st day) ***Number of days?*** _____

Duration of Bleeding? From _____ to _____ Days

Bleeding(Spotting) In between periods? ☐ Y ☐ N

With your periods do you have: ☐ Pain ☐ Cramps ☐ Bloating

Any Premenstrual Symptoms? (eg.: irritability, depression, anxiety, breast pain? ☐ Y ☐ N

Time lost from school / work because of periods? ☐ Y ☐ N

BIRTH CONTROL

Current Method

How Long?

If Pill - Brand?

Past Methods

Comments / Problems

Women's Health History Questionnaire

SEXUAL HISTORY
Are you sexually active? ☐ Y ☐ N
Wish to Discuss? ☐ Y ☐ N
Any concerns or problems with intercourse? ☐ Y ☐ N
Pain or Bleeding with intercourse? ☐ Y ☐ N

PELVIC EXAM Date of last exam

PAP TEST Date of last test ☐ Normal ☐ Abnormal

INFECTIONS
At present – Any abnormal vaginal discharge? ☐ Y ☐ N
History of ☐ Yeast Infections ☐ Chlamydia ☐ Gonorrhea ☐ Trichomonas ☐ Herpes ☐ Bacterial Infection ☐ Urinary Infections

BREASTS
Do You – Routinely check your breasts? ☐ Y ☐ N
Have any nipple discharge? ☐ Y ☐ N
Have any - ☐ Painful ☐ Tender OR ☐ Lumpy Breasts?
have any other concerns? ☐ Y ☐ N

SOCIAL HISTORY
Smoking – Cigarettes/Day ____ # of years ____
Alcohol - Oz/week ____
Coffee - Cups/Day ____
Street Drugs ____

REVIEW OF SYSTEMS – Have you had problems with any of the following within the past year?

General
- ☐ Weight Loss or Gain
- ☐ Fevers
- ☐ Trouble Sleeping
- ☐ Chronic Fatigue
- ☐ Excessive Bleeding
- ☐ Easy Bruising
- ☐ Abnormal Thirst

Eyes
- ☐ Itchy, Red Eyes
- ☐ Vision Problems

Ears
- ☐ Ear Pain
- ☐ Ringing in Ears
- ☐ Hearing Loss

Nose
- ☐ Sinus Problems
- ☐ Nose Bleeds

Mouth
- ☐ Sore Throat
- ☐ Mouth Sores
- ☐ Dental Problems

Lungs
- ☐ Coughing up Blood
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Blood Clot in Lungs
- ☐ Painful Breathing
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Ankle/Hand Swelling

Gastrointestinal
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Bloody Stools
- ☐ Nausea/Vomiting
- ☐ Hemorrhoids

Urinary
- ☐ Incomplete Urination
- ☐ Loss of Urine
- ☐ Painful Urination
- ☐ Bloody Urine

Musculoskeletal
- ☐ Muscle Weakness
- ☐ Joint Pains
- ☐ Joint Swelling
- ☐ Clot in Leg Vein

Neurologic
- ☐ Frequent/Severe Headaches
- ☐ Dizziness
- ☐ Seizures
- ☐ Numbness
- ☐ Trouble Walking
- ☐ Fainting Spells

Skin
- ☐ Acne
- ☐ Change in Hair – Growth, Loss, Texture
- ☐ Unusual Lump or Growth
- ☐ Change in Moles, Freckles

Neurologic/Psychiatric
- ☐ Memory Change
- ☐ Depression/Anxiety
- ☐ Numbness/Tingling
- ☐ Serious thoughts of harming yourself or others

Menstrual Problems
- ☐ Cramps/Pain
- ☐ Heavy Bleeding
- ☐ Too Frequent Periods
- ☐ Bleeding Between Periods
- ☐ Missed a Period
- ☐ Other Period Issue

Pre Menstrual Problems
- ☐ Bloating/Swelling
- ☐ Mood Changes
- ☐ Breast Changes
- ☐ Headaches
- ☐ Acne
- ☐ Other PMS Issue

Menopause Issues
- ☐ Hot Flashes
- ☐ Night Sweats

Breast Problems
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Nipple Discharge
- ☐ Other Breast Issue

Other Gynecologic Issues
- ☐ Vaginal Discharge
- ☐ Itching/Irritation
- ☐ Vulvar Pain
- ☐ Vulvar Lump/Growth
- ☐ Vulvar Sores

Sexual Problems
- ☐ Painful Intercourse
- ☐ Bleeding after Intercourse
- ☐ Decreased Desire
- ☐ Orgasm Problems
- ☐ Dryness
- ☐ Possible Exposure to STD
- ☐ Other Sexual Issue

Would you like to discuss any of the following?
- ☐ Contraception
- ☐ Menopause Issues
- ☐ Pregnancy Issues
- ☐ Self Breast Exam
- ☐ Sexuality Issues
- ☐ SDTs
- ☐ Other

Patient Signature _____ **Date:** _____

Physician Signature _____ **Date** _____ **Time:** _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)