Patient Name:

Date of Birth:

Female Reproductive Health History

Self and Family Medical History

Please mark an X below for Self and Family History.

HISTORY	SELF	MOM	DAD	BROTHER	SISTER	CHILD	GRANDMOTHER	GRANDFATHER
Anemia	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Sickle Cell	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Bleeding Problems	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Heart Disease	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Diabetes	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
High Cholesterol	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Hypothyroid (low)	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Hyperthyroid (high)	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Endocrine	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Lung Disease	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Kidney Disease	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Seizure Disorders	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Hepatitis	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Liver Problems	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Migraine Headaches	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Cancer Please list type of cancer below any checked boxes.	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Blood Clots in Legs	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Blood Clots in Lungs	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Mental Illness	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Emotional Disorders	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Transfusion of Blood or Blood Products	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Birth Defects	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Genetic Problems	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side
Tuberculosis	☐	☐	☐	☐	☐	☐	☐Mom's Side ☐Dad's Side	☐Mom's Side ☐Dad's Side

If any family member's disease has resulted in death please list here:

____

Self-History

List hospitalizations, surgeries and dates:

____

____

Pregnancy & GYN

# of Pregnancies ________ # of Children ________ # of Miscarriages ________ # of Abortions ________

Date of last pregnancy ________________________

Age of First Period___________

Social History

Do you smoke or use smokeless tobacco? ☐No ☐Yes If yes, how much? ____

If no: ☐Never Smoker ☐ Former Smoker

Drink alcohol? ☐No ☐Yes If yes, how much? ____

Exercise? ☐No ☐Yes If yes, how often? ____

Drink Caffeine? ☐No ☐Yes If yes, how much? ____

Take Street Drugs? ☐No ☐Yes If yes, how much? ____

Are you regularly around someone else who uses alcohol, tobacco, electronic nicotine devices or street drugs? ☐No ☐Yes

If yes, what do they use? _______________ How often? ______________

(More on back) ⟶

Allergies

Allergy Name	Reaction	Severity
		□ Mild □Moderate □Severe
		□ Mild □Moderate □Severe
		□ Mild □Moderate □Severe
		□ Mild □Moderate □Severe

Medications -Please list any medications (prescription or over the counter), diet or herbal supplements:

Name (Ex. Lopressor)	Dosage (Ex. 50mg)	Frequency (Ex. Twice Daily)	Prescriber	Start Date

Current Method

Are you using birth control currently? □No □Yes If yes, what are you using? ______________________________

Are you satisfied with your current method? □No □Yes If no, which method do you desire? ______________________

Sexual History

Have you had any unprotected intercourse in the past 5 days? _______________

Do you have sex with? □ Men only □ Women only □ Both men and women

In the past two months, how many partners have you had sex with? ______

In the past 12 months, how many partners have you had sex with? _______

Is it possible that any of your sex partners in the past 12 months had sex with someone else while they were still in a sexual relationship with you? □ Yes □ No

What do you do to protect yourself from STDs and HIV?

____

What ways do you have sex? □ vaginal □ oral □ anal

Do you or your partner use condoms and/or dental dams every time you have vaginal, oral or anal sex? □ Yes □ No

Have you ever had an STD? □ Yes □ No If yes, which STD and when? ____

Have any of your partners had an STD? (i.e., chlamydia, gonorrhea, trichomoniasis, herpes, syphilis, hepatitis B, others) □ Yes □ No

If yes, which STD and when?

____

Have you or any of your partners ever injected drugs? □ Yes □ No

Have you or any of your partners exchanged money or drugs for sex? □ Yes □ No

Have you had a HIV test? □ Yes □ No If so, when? ____

Do you wish to have a HIV test today? □ Yes □ No

Mental Health History

During the past two weeks, have you often been bothered by any of the following problems?

Feeling down, depressed, irritable or hopeless □ Yes □ No or

Little interest or pleasure in doing things □ Yes □ No

Felt like harming yourself or others? □ Yes □ No

Are you in a relationship with a person who threatens or physically hurts you? □ Yes □ No

In the past year, have you been slapped, kicked or otherwise physically hurt by someone? □ Yes □ No

Have you been forced into sexual relations when you were not willing? □ Yes □ No