

Women's Health Department Initial History (Uptown)

Name: _____ SS#: _____ Date of Birth: _____ Age: _____

A. GENERAL HEALTH

Have you or your immediate family (blood relatives - parents, grandparents, sisters, brothers) had any of these problems?

PROBLEM	SELF		FAMILY		COMMENTS
	YES	NO	YES	NO	
Are you adopted?					Allergic to metals, latex, food, medications: Kind: _____
Severe/frequent headaches?					
Eye disease?					Are you taking any medications now? (Including birth control pills) <input type="checkbox"/> Yes <input type="checkbox"/> No Kind: _____
Stroke?					
Epilepsy/seizures					Have you ever used street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Kind: _____
Depression/suicide/psychiatric problem					
Chest pain?					How taken into the body? Date last used: _____
Difficulty breathing, asthma?					
Thyroid problems?					Do you drink alcoholic drinks? <input type="checkbox"/> Yes <input type="checkbox"/> No Kind: _____ #a week _____
TB/Lung disease?					
Heart Attack (before 50)?					Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No # a day _____ # of years _____
High Blood pressure/heart disease					
High cholesterol/fat?					Have you ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Kind: _____
Anemia?					
Sickle cell anemia?					Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No Kind: _____ _____ (date and reason)
Rheumatic fever?					
Severe abdominal pain?					Have you ever had a recurrent problem with omitting, binge eating, laxative use or diuretic use? <input type="checkbox"/> Yes <input type="checkbox"/> No Kind: _____
Hepatitis/liver disease?					
Gall bladder disease?					Kind: _____
Frequent nausea/vomiting?					
Cancer?					Kind: _____
Diabetes?					
Breast disease/lump?					Kind: _____
Overweight?					
Kidney/bladder problems?					Kind: _____
Pain/burning on urination?					
Arm or leg pain/numbness?					Kind: _____
Varicose veins?					
Genetic problems?					Kind: _____
Other/chronic disease?					
Do you have a clotting or bleeding disorder?					Kind: _____
Blood clot/Phlebitis?					
Alcoholism/drug addiction					

Comments: _____

Name: _____ SS#: _____

B. GYNECOLOGICAL HISTORY (Important - Fill out)

Age when you started your period _____ How many days to you normally bleed? _____
 How many pads or tampons do you use during your heaviest days of flow? _____
 How many days do you have from the **start** of one period to the **start** of the next? _____
 Month/Year of Last PAP Smear: _____/_____
 Have you ever had an abnormal PAP? Yes No If yes, when and what was the diagnosis? _____
 What types of treatment (if any)? _____
 Have you ever been told you have a problem with your uterus, cervix, ovaries, vagina, and/or breast? Yes No
 Any reproductive abnormalities? Yes No

Do you now have or in the recent past (6 months or less) had:	Never	Now	Past	COMMENTS
Vaginal infections				
Unusual vaginal discharge/odor				
Vaginal itching/burning/"sores"				
Pain or bleeding with intercourse				
Bleeding/Spotting between periods				
Menstrual cramping/pain with period				
Are you able to relieve this pain? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you miss activities because of this pain? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Discomfort before periods: breast tenderness				
Weight gain, irritability				
Unusual or missed periods				

Are you aware that Birth Control Pills **DO NOT** protect you against sexually transmitted diseases (STD)? Yes No
 Do you know that you can get chlamydia, gonorrhea, herpes, as well as other sexually transmitted diseases from oral sex? Yes No

Is there any other information about yourself you think we should discuss? _____

C. SOCIAL HISTORY:

Have you been affected by any of the following:

- Yes No
- Has your partner (husband, boyfriend, girlfriend) ever made you have sex against your will?
 - Do you feel you have a good social support network?
 - Are you satisfied with your body image, body weight, and/or eating patterns?
 - Major physical illness. Explain _____
 - Are you afraid of your partner?
 - Are you, or have you ever been a victim of family/domestic violence?
 - Have you ever seen a mental health professional?
 - Is there anything going on in your life currently that may be helped by a mental health professional? _____
 - Have you ever been a victim of a violent crime, or a witness to sexual assault?

D. SEXUAL AND CONTRACEPTIVE HISTORY (If you have never been sexually active, you may skip to Section E.)

1. Have you ever had a sexual experience? Yes No
 male partner female partner vaginal sex oral sex anal sex other _____
2. Current sexual orientation? _____
3. How long have you been sexual with your present partner? _____
4. Last time you had sex? _____

5. How old were you when you first had sex? _____ How many sex partners have you had in the last year? _____
 Number of sex partners in the past 30 days _____ How many sex partners have you had in your life? _____
6. Do you have any questions about sex? Yes No Explain _____
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7. What do you use to protect yourself from sexually transmitted disease (STD)? _____
8. Which birth control method are you currently using? _____
9. How long have you used this method? _____
10. Do you have any problems with this method? Yes No Kind _____
11. What method do you want to use now? _____
12. Since your last period, have you had sex without using a birth control method? Yes No
 No. of pregnancies _____ No. of live births _____ No. of miscarriages _____ No. of elective terminations _____

Please (circle) all contraceptive methods currently used, or used in the past: Abstain (no sex), Sterilization, Birth Control Pills, Foam/Cream/Suppository, Rhythm/Counting Days, Natural Family Planning, Withdrawal, Rely on Partner, Sponge, I.U.D.	COMMENTS
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Have you ever had (please circle): Herpes, Syphilis, Gonorrhea, Chlamydia, Warts, other STD PID/infection of uterus, tubes, ovaries Other (specify) _____	COMMENTS
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Has a partner (to your knowledge) ever had (please circle): herpes, syphilis, gonorrhea, chlamydia, warts Other STD _____	COMMENTS
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E. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT AND COMPLETE.

I understand I will be charged a fee for all lab work (i.e., pap smear, chlamydia, etc.)

Patient's signature: _____ SS# _____ DATE _____

INITIALS/CLINICIAN REVIEWING HISTORY _____ DATE _____

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