Associates in WOMEN'S HEALTH

Health History for Patients Under Age 50

Date: ________________
Patient #: ______________

NAME: ____ DOB: __________________

Who is your primary care physician? ____

When was the 1st day of your last menstrual period? ___________________

Are you currently pregnant? **YES** **NO**

Total number of pregnancies? _________

Total number of births? ________

Have you ever had a miscarriage? **YES** **NO**

Have you ever had an abortion? **YES** **NO**

What are you currently using for contraception? _____________________________

Are you experiencing any problems with it? If yes, explain: ____________________________________

How old were you when you started your period? _________________

How often are your periods?

____ less than 21 days ____ every 22-33 days ____ greater than 34 days

How long does your period last? _______________

Are you periods painful? **YES** **NO** If yes, explain: ____

Do you take anything for the pain? __________________________________

Do you experience any bleeding between cycles? **YES** **NO** If yes, explain: _____________________

Are you having any problems with sex? **YES** **NO**

____ Pain with intercourse ____ Difficulty with lubrication ____ Decreased sex drive

Have you ever had any of the following STD's?

____ Chlamydia ____Herpes (genital) ____HPV (warts) ____ Trichomonas

____ Gonorrhea ____ HIV ____ Syphilis

Do you have, or have you ever had any of the following medical problems:

____ Anxiety
____ Asthma
____ Blood clots
____ Cancer - Type: ____________________________
____ Dense breast tissue
____ Depression
____ Diabetes ___ insulin ___ non-insulin
____ Frequent urinary tract infections
____ Heart disease
____ High blood pressure
____ High cholesterol
____ Liver disease (Hepatitis)
____ Migraines
____ Thyroid problems
____ Seizure disorder

Other____
____

Past surgical history: (**Please include date of surgery**)

____
____

See other side>>>>>>

Medications you are currently taking: (**Please include the dosage**)

____

____

Do you have any allergies to medications? If yes, please list:

____

____

Do you have a Latex allergy: **YES** **NO**

Do you have a family history of any of the following? (**Please include relation, age when diagnosed & if on mother's or father's side**)

Ashkenazi Jewish Heritage ______________________

Breast Cancer ______________________

Diabetes ______________________

Endometrial Cancer ______________________

Colon Cancer ______________________

Colorectal Polyps ______________________

Genetic Mutations ______________________

Heart Disease ______________________

High Blood Pressure ______________________

Ovarian Cancer ______________________

Pancreatic Cancer ______________________

Skin Cancer ______________________

Other ______________________

____

Race: ______________________

Do you consider yourself to be: **STRAIGHT** **GAY/LESBIAN** **BISEXUAL**

What do you do for a living? ______________________

Marital Status: **SINGLE** **MARRIED** **SEPARATED** **DIVORCED** **WIDOWED**

Sexually active: **YES** **NO**

If yes, how long have you been with current partner? ______________

Tobacco use: **CURRENT** **FORMER** **NEVER**

If current, how many cigarettes a day? __________ If former, when did you quit? ______________

Alcohol use: **NONE** **RARLEY** **OCCASIONAL** **HEAVY**

How many drinks per day: ________ or per week: __________

Drug use: **NONE** **MARIJUANA** **COCAINE** **HEROIN** **IV DRUGS**

Caffeine use: **YES** **NO**

If yes, how may cups a day? __________

Have you ever had your Cholesterol checked? **YES** **NO** When? ______________

When was your last Pap smear: ______________________

Have you ever had an abnormal pap smear? **YES** **NO** If yes, when? ______________

Have you ever had a Mammogram? **YES** **NO** When? ______________ **NORMAL** **ABNORMAL**

Have you had the chicken pox? **YES** **NO** If yes, when? ______________

Have you received/completed the Gardasil (HPV) vaccinations? **YES** **NO** If yes when? __________

Pharmacy Name: ______________________ Address: ______________________

Pharmacy Number: ______________________