Associates in WOMEN'S HEALTH

Date: _____
Patient #: _____

Health History for Patients Age 50 And Over

NAME: _____ DOB: _____

Who is your primary care physician? _____

Do you still have a period? **YES** **NO**
If yes, are they: ____ less than 21 days ____ every 22-33 days ____ greater than 34 days
____ Considerably heavier than before

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 having any problems with sex? **YES** **NO**
____ Pain with intercourse ____ Difficulty with lubrication ____ Decreased sex drive

Do you currently have any of the following problems?

____ Difficulty sleeping	____ Hot flashes	____ Osteopenia
____ Depression	____ Irritability/Mood changes	____ Osteoporosis
____ Frequent bladder infections	____ Loss of bladder control	____ Painful intercourse
____ Frequent vaginal infections	____ Memory loss	____ Vaginal burning

Have you ever taken Estrogen? **YES** **NO**
Are you currently taking Estrogen now? **YES** **NO**
Any problems with Estrogen? **YES** **NO**

____ Breast tenderness	____ Headaches	____ Weight gain
____ Bloating	____ Irregular bleeding	____ Other _____

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

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 _____ Heart Disease _____

Breast Cancer _____ High Blood Pressure _____

Diabetes _____ Ovarian Cancer _____

Endometrial Cancer _____ Pancreatic Cancer _____

Colon Cancer _____ Skin Cancer _____

Colorectal Polyps _____ Other _____

Genetic Mutations _____ _____

Race: _____

What do you do for a living? _____

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

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? _____

When was your last Mammogram? _____
Have you ever had an abnormal mammogram? **YES NO** If yes, when? _____

When was your last Bone Density scan? _____

When was your last Colonoscopy? _____
Have you ever had an abnormal colonoscopy? **YES NO** If yes, when? _____

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

Pharmacy Name: _____ Address: _____
Pharmacy Number: _____