FEMALE MEDICAL HISTORY

This information is confidential and will be used by your medical provider to make sure you get proper care.

☐ Yes ☐ No  Are you allergic to any medications? List here:

☐ Yes ☐ No  Do you take any over the counter medicines, prescription medicines, vitamins, supplements, or home remedies? List here:

☐ Yes ☐ No  Do you have a usual source of primary care? If yes, who?

A. Family Medical History:

Has anyone in your family (mother, father, brother, sister) ever had:

4. ☐ High blood pressure
5. ☐ High cholesterol

B. Personal Medical History:

1. Have YOU ever had problems with any of these? Check all that apply.

A. ☐ Heart disease  K. ☐ Sickle cell disease  S. ☐ Gall bladder disease
B. ☐ High blood pressure  L. ☐ Kidney/bladder problems  T. ☐ Eating disorder
C. ☐ Stroke  M. ☐ Seizures or epilepsy  U. ☐ Cancer
D. ☐ Diabetes  N. ☐ Depression  Type: __________
E. ☐ High cholesterol  O. ☐ Suicidal thoughts  V. ☐ Thyroid disease
F. ☐ Tuberculosis (TB)  P. ☐ Mental illness  W. ☐ Fibroids
G. ☐ Asthma  Q. ☐ Severe headaches or migraines  X. ☐ Ovarian cyst/abnormality
H. ☐ Blood clot in legs/lungs  R. ☐ Liver problems or hepatitis
I. ☐ Bleed/bruise easily  S. ☐ Gall bladder disease  Y. ☐ Endometriosis
J. ☐ Anemia
K. ☐ Stroke
L. ☐ High blood pressure
M. ☐ Diabetes
N. ☐ Heart attack/disease
O. ☐ Sickle cell disease
P. ☐ Kidney/bladder problems
Q. ☐ Seizures or epilepsy
R. ☐ Mental illness
S. ☐ Depression
T. ☐ Eating disorder
U. ☐ Cancer
V. ☐ Thyroid disease
W. ☐ Fibroids
X. ☐ Ovarian cyst/abnormality
Y. ☐ Endometriosis
Z. ☐ Infertility

2. ☐ Yes ☐ No  Have you ever been hospitalized or had any surgery? If yes, when and why?

3. ☐ Yes ☐ No  Have you ever had a transfusion or blood exposure?

4. ☐ Yes ☐ No  Have you been immunized against rubella? ☐ I do not know

5. ☐ Yes ☐ No  Have you been immunized against hepatitis B? ☐ I do not know

6. When was your last Pap smear? ☐ I never had a Pap smear

☐ Yes ☐ No  Have you ever had an abnormal Pap smear? If yes, when?

7. ☐ Yes ☐ No  Have you ever had an HIV test?

If yes, when was your last one? Was it: ☐ Positive ☐ Negative?

8. ☐ Yes ☐ No  Have you ever had a mammogram?

If yes, when was your last one? Was it normal?

C. Menstrual History:

1. Age period started: _______

2. Periods come every _______ days and last _______ days.

3. Periods are: ☐ Regular ☐ Irregular ☐ Painful ☐ Light ☐ Moderate ☐ Heavy

4. ☐ Yes ☐ No  Do you have bleeding or spotting in between your periods?

D. Pregnancy History: (If you have never been pregnant, skip to next section)

1. Please list the number of the following: _____ Pregnancies _____ Live births _____ Abortions _____ Miscarriages _____ Ectopic (tubal) pregnancies

2. How long ago was your last pregnancy? _______ month(s), _______ year(s)

3. ☐ Yes ☐ No  Are you currently breastfeeding?
### E. Contraception History:

1. How old were you when you first had vaginal intercourse? _______ years old  ❑ I never had sex
2. How important is it for you to avoid pregnancy now?  ❑ Very  ❑ Somewhat  ❑ Not at all
3. What birth control methods have you used in the past?  ❑ None
   - A. ❑ Condoms/rubbers
   - B. ❑ Birth control pills
   - C. ❑ DepoProvera/shot
   - D. ❑ Patch
   - E. ❑ NuvaRing (vaginal ring)
   - F. ❑ IUD
   - G. ❑ Implants under the skin
   - H. ❑ Diaphragm/cervical cap
   - I. ❑ Tubal ligation/tubes tied
   - J. ❑ Foams/film or jelly
   - K. ❑ Intrauterine device
   - L. ❑ Intrauterine device (IUD)
   - M. ❑ Partner has vasectomy

4. What birth control are you and your partner(s) currently using? _____________________________  ❑ None
5. ❑ Yes  ❑ No  Are you happy with your method?
6. How often do you use condoms?  ❑ Always  ❑ Sometimes  ❑ Never
7. ❑ Yes  ❑ No  Have you ever used emergency contraception (morning after pill/Plan B)?
8. ❑ Yes  ❑ No  ❑ Maybe  Are you planning to get pregnant in the next two years?

### F. Habit and Lifestyle:

If you prefer, you can talk to your health care provider about these important questions.

1. How many glasses of an alcoholic beverage do you have per week? ___________  ❑ None
2. ❑ Yes  ❑ No  Do you smoke cigarettes?  If yes, how many cigarettes per day? ___________
3. ❑ Yes  ❑ No  Do you use street drugs?  If yes, please list: ___________________________
4. ❑ Yes  ❑ No  Have you ever used injected drugs?
5. ❑ Yes  ❑ No  Have you ever shared needles?
6. ❑ Yes  ❑ No  Has anyone ever told you that you have a problem with drugs or alcohol?
7. ❑ Yes  ❑ No  Is anyone, including your partner, threatening you, causing you to be afraid, or hurting you physically?
8. ❑ Yes  ❑ No  Have you ever been pressured or forced to have sex when you did not want to?
9. Have you ever had a sex partner with a history of:  ❑ Injected drug use  ❑ Sex with men  ❑ HIV

### G. Sexual History:

In the last 12 months...

1. ❑ Yes  ❑ No  Have you been sexually active?  If no, skip to #6.
   - If yes, how many sexual partners have you had? _______
2. Have you had sex with:  ❑ Men  ❑ Women  ❑ Both
3. Have you and/or your partner(s) had:  ❑ Oral sex  ❑ Anal sex  ❑ Vaginal sex?
4. ❑ Yes  ❑ No  Have you traded sex for money or drugs?
5. Do you think that your partner has other sexual partners?
   - ❑ Yes, definitely  ❑ Not sure, possibly  ❑ No, very unlikely
6. In the last 12 months have you or your sex partner(s) had any of the following:
   - A. ❑ Chlamydia
   - B. ❑ Gonorrhea
   - C. ❑ Genital Herpes
   - D. ❑ Trichomoniasis (Trich)
   - E. ❑ Pelvic Inflammatory Disease
   - F. ❑ Genital warts
   - G. ❑ Bacterial vaginosis (BV)
   - H. ❑ Syphilis
   - I. ❑ Other: ___________________________

7. ❑ Yes  ❑ No  Is there anything else about your health or sexual practices that you would like to discuss with your clinician?

________________________________

________________________________

________________________________

Patient Signature/Date  ____________  Clinician Signature/Date  ____________

Clinician Signature/Date Updated  ____________  Clinician Signature/Date Updated  ____________