

**Pacific Women's Center
Medical History Form**

Today's Date: ___/___/___ Main reason for visit: _____

Birth date: _____ Age: ___ Occupation: _____

Last Name, First Name MI

Partner's Name: _____ Age: _____ Occupation: _____

Primary Care Physician: _____

Current Medications: Please include herbs and/or nutritional supplements.

Medication	Dose	How Often?	Medication	Dose	How Often?

Medical History:

Have you ever experienced any serious problems with the following: *Please circle one* → Y = Yes and N = No

Headaches	Y N	Herpes	Y N
Hearing/Vision Loss	Y N	Chlamydia	Y N
Fainting/Seizures/Epilepsy	Y N	Gonorrhea	Y N
Heart Disease/Rheumatic Fever	Y N	Genital Warts (HPV)	Y N
High Blood Pressure	Y N	Ovarian Cysts/Tumors	Y N
High Cholesterol	Y N	Uterine/Cervical Growth	Y N
Pneumonia/Bronchitis/Asthma	Y N	Pelvic Infections	Y N
Stomach/Colon Problems	Y N	Varicose Veins/Blood Clots	Y N
Kidney/Bladder Infections	Y N	Recent Weight Loss/Gain	Y N
Mental Health Problems	Y N	Anemia/Sickle Cell Anemia	Y N
Eating Disorders	Y N	What is your height?	Y N
Serious Infections/Hepatitis	Y N	Other:	_____
Diabetes	Y N	_____	_____
Thyroid Problems	Y N	_____	_____

Allergies:

Please list any allergy you have to medication(s), food(s) and/or other substances:

Gynecological History:

First day of last normal menstrual period was: ___/___/___ Age of menopause, if applicable: _____

Age of first period: _____ Cramps: Yes No Heavy flow: Yes No

How long are your menstrual cycles (ie: 28-30 days apart)? _____ Average length of flow: _____

Date of last pap smear: _____ Have you ever had an *abnormal* pap smear: Yes No

If yes, when was it done? _____ Where? _____

Present Birth Control Method: _____ Questions or concerns about birth control? Yes No

Breast History:

Have you ever had a mammogram? Yes No Date of last mammogram: ___/___/___

Have you had a breast biopsy? Yes No Do you do monthly self-breast exams? Yes No

Pregnancy History:

Number of: Pregnancies _____ Live Births _____ Miscarriages _____ Elective Abortions _____

If post menopausal, you can skip the following.

What problems did you have with prior pregnancies, births or abortions? _____

Child	Date of Birth	Due Date	Hrs. of Labor	C-Section or Vag Birth	Medications	Sex	Weight	Place of Birth	Name of Child
1 st									
2 nd									
3 rd									
4 th									

Surgical History:

Please list surgeries or hospitalizations you have had in chronological order, giving approximate date:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Have you had a blood transfusion: Yes No

Family History:

Has any member of your family, including parents, grandparents, or siblings ever had the following (please list person involved):

Diabetes: _____	Twins: _____
High Blood Pressure: _____	Lung Disease: _____
High Cholesterol: _____	Cancer: _____
Kidney Disease: _____	Heart Disease: _____
Seizures: _____	Alzheimer's: _____
Osteoporosis: _____	Other: _____
Birth Defects: _____	_____

Social History:

What do you do for exercise? _____

Do you think you have a healthy diet? Yes No Do you take calcium? Yes No

Do you consume: Coffee _____ How much/day _____ Dark tea _____ How much/day _____

Colas _____ How much/day _____ Chocolate _____ How much/day _____

Have you ever smoked? _____ Do you smoke currently? _____ How much/day? _____

Do you drink alcoholic beverages? _____ How much/day? _____

Do you use recreational drugs? _____ Which ones? _____ How much? _____

Have you ever shared needles? _____ Have you had an HIV test? _____

On a scale of 1-10 (1=poor, 10=very good) how would you rate your work situation? _____

Home? _____ Relationship with partner? _____

What is the length of your present relationship? _____

Do you have concerns about your sex life? _____ Is sex painful? _____

Have you ever been forced to have a sexual encounter? _____

Are you concerned about your safety? _____

Do you have other concerns or comments? _____