

**DEWITT-PIATT BI-COUNTY HEALTH DEPARTMENT
WOMEN'S HEALTH HISTORY**

Name _____ Chart # _____ Date _____

Age _____ Birthdate _____

Reason for your visit today: _____

We have tried to make this form as complete as possible; realizing that some questions will not apply to every woman's particular circumstances. All information is strictly confidential.

YES NO **FILL THIS OUT IF YOU ARE UNDER 18 YEARS OLD**

____ Are your parents aware of your visit?
____ If not, did you discuss plans to come to the clinic with another adult? Who? _____
____ Would you like information on talking to your parents about sexuality?

CONTRACEPTIVE HISTORY

Check all birth control methods you have used: ___ Pill, kind/s _____ Depo Provera (shot) ___ Norplant
___ IUD ___ Condoms ___ Sterilization (tubes tied) ___ Diaphragm/cap ___ Sponge ___ Foam/Suppository/Film ___ Withdrawal
___ Abstinence ___ Natural Family Planning (Rhythm, Calendar) ___ Hysterectomy ___ Other: _____

YES NO

____ Do you or your partner use birth control now?
If yes, what method(s) do you use? _____ How long have you used this method? _____
____ Have you had problems with this or any birth control method? If yes, explain _____
____ Do you want children in the future? If yes, when _____
____ Do you want a birth control method today? If yes, what method _____

MENSTRUAL HISTORY

Age periods started: _____
Last period started: _____
Periods are: ___ regular ___ irregular
___ Light ___ moderate ___ heavy
Periods come every _____ days, and last _____ days.
Number pads/tampons used on heaviest day of period _____

YES NO

____ Was your last period normal and on time?
____ Have you had intercourse since your last period?
____ Could you be pregnant now?
____ Severe cramps?
____ Missed periods?
____ Bleeding between periods/bleeding with intercourse?

PREGNANCY HISTORY ___ Never pregnant (skip to next section)

Age at first pregnancy: _____ Total pregnancies: _____

	DATES	NUMBERS
Abortion(s)	_____	_____
Miscarriages	_____	_____
Still births	_____	_____
Ectopic pregnancies	_____	_____
Cesarean births	_____	_____
Vaginal births	_____	_____
Live births	_____	_____
Living children	_____	_____
Genetic/Newborn abnormalities: specify: _____		
Gestational diabetes: toxemia: high blood pressure? _____		
Are you breastfeeding now? Yes No		

SEXUAL HISTORY

Age at first intercourse: _____

Yes No

____ Are you sexually active now? If no, do you plan to become sexually active in the near future? ___ Yes ___ No
If yes, complete the following:
How many partners in the past 12 months? _____
How long with current partner? _____
Type of Sex: ___ vaginal ___ anal ___ oral ___ other
How often? _____ times () week () month () year
Are your partner(s): ___ male ___ female ___ both
____ Do you use condoms for protection against sexually transmitted diseases? ___ always ___ sometimes ___ never
____ Do you feel that any of your partners have put you at risk for sexually transmitted diseases/HIV? ___ Unsure
____ Do you want to be tested for sexually transmitted diseases/HIV?
____ Have you ever had sex with someone who has been incarcerated?
____ Have you ever had sex while high or drunk?

SOCIAL/HEALTH RISK HISTORY/HABITS & LIFESTYLES:

Yes No

____ Do you drink or use caffeine? Coffee ___ Tea ___ Soda/Pop ___ Chocolate ___ Pills ___
____ Do you smoke? How many cigarettes daily? ___ How long have you smoked? _____
____ Do you use alcohol? Number of drinks per day ___ per week ___ per month ___ per year ___
____ Do you or your partner(s) use street or IV (injectable) drugs? If so, list _____
____ Have you or your partner(s) ever shared needles of any kind (piercing, tattooing, drugs)?
____ Are you now or have you ever been in a relationship where you have been physically hurt or threatened?
____ Are you in a relationship where you are being forced to have sexual relations?

Name _____ Chart # _____ Date _____

ALLERGIES: Please list any allergies, including **Latex**, drug, metal, skin allergies or irritants.

FAMILY HISTORY (Mother, Father, Brother, Sister) Are you adopted? Yes No
 High blood pressure High cholesterol/triglycerides Other cancer, what kind? _____
 Stroke Diabetes (insulin dependent?) Genetic problems/birth defects
 Heart Attack Breast, ovarian, uterine cancer Other serious medical problems?

COMMENTS: _____
Women born 1940-1970: Did your mother take DES (hormones) during her pregnancy with you? Yes No

PAST MEDICAL HISTORY

Have you ever had surgery or been a patient in a hospital? Yes No

If yes, describe: _____

Are you now, or have you ever been, under a doctor's care for a serious illness, injury or condition? Yes No

If yes, describe: _____

List any prescription medications you are now taking, or take often: _____

List all over-the-counter or herbal medications and vitamins you use: _____

Do you have any other source of medical care? Yes No Where? _____

REVIEW OF SYSTEMS: Have you had, or do you have, any of the following (please check **each** item):

- | | | | | | |
|---|--------------------------|---|--------------------------|--|--------------------------|
| 1. General | | 5. Gastrointestinal | | 9. Hematological | |
| YES | NO | YES | NO | YES | NO |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My health is generally good | | Stomach/bowel problems | | Anemia | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Recent weight gain or loss | | Liver disease/jaundice/mono | | Blood clotting disorder | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer _____ | | Hepatitis | | Blood transfusion prior to 1985 | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Genetic Condition | | Gall bladder disease | | Sickle Cell Anemia/
Trait/Thallemia | |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Endocrine | | 10. Skin | |
| Communicable disease | | <input type="checkbox"/> Diabetes/Diabetes with pregnancy | | <input type="checkbox"/> Acne | |
| 2. Immunizations | | <input type="checkbox"/> Thyroid Problems | | <input type="checkbox"/> Tattoo/piercing | |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Respiratory | | <input type="checkbox"/> Other skin problems | |
| Vaccine for Rubella(MMR) | | <input type="checkbox"/> Asthma | | 11. Musculoskeletal | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chronic cough/shortness of breath | | <input type="checkbox"/> Arthritis: joint problems | |
| Tetanus Vaccine shot | | <input type="checkbox"/> Other breathing problems/TB | | <input type="checkbox"/> Broken bones/fractures | |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Genitourinary | | 12. Eyes, Ears, Nose, Throat, Mouth | |
| Hepatitis B vaccine | | <input type="checkbox"/> Frequent bladder infections (>3/year) | | <input type="checkbox"/> Eye problems (other than
glasses) | |
| 3. Cardiovascular | | <input type="checkbox"/> Bladder, urinary or kidney problems | | <input type="checkbox"/> Hearing problems | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Abnormal Pap smear | | <input type="checkbox"/> Frequent nosebleeds | |
| Heart Disease/Murmur/Problems | | <input type="checkbox"/> Pelvic infection/Pain/PID | | <input type="checkbox"/> Frequent sore throats | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Recurrent Vaginal Infection/discharge | | <input type="checkbox"/> Teeth/Gum problems | |
| High Cholesterol/triglycerides | | <input type="checkbox"/> Sexually transmitted disease | | 13. Psychology | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chlamydia/Gonorrhea/Herpes | | <input type="checkbox"/> Depression | |
| High blood pressure | | <input type="checkbox"/> Syphilis/Genital Warts/Other | | <input type="checkbox"/> Anxiety | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Breast problems: Discharge/
Disease/Tumor/Surgery | | <input type="checkbox"/> Severe mood swings | |
| Thrombophlebitis/blood clots
in veins or lungs | | <input type="checkbox"/> Mammogram | | <input type="checkbox"/> Under care of psychiatrist/
psychologist | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Date of last one: _____ | | | |
| Chest pains | | | | | |
| Varicose veins | | | | | |
| 4. Neurologic | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| Stroke | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| Migraine/Severe headaches | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| Sensory difficulties (numbness,
hearing, taste, smell) | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| Blurred/double vision | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| Seizures/Epilepsy/fainting spells | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | |

TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS COMPLETE AND CORRECT.

Patient Signature: _____ Date: _____

Staff Comments: _____

Clinician Signature: _____ Date: _____

Annual Review #1

No change Change (see physical exam notes)

Clinician Signature _____ Date: _____

Annual Review #2

No change Change (see physical exam notes)

Clinician Signature _____ Date: _____

