Female Health History

Form G

Name______________________________
DOB____/____/____

Medical History

Have you or anyone in your immediate family had a history of the following:

		YES	NO
1.	Congenital anomalies/genetic disorders	Ž	Ž
2.	Multiple births	Ž	Ž
3.	Diabetes mellitus	Ž	Ž
4.	Cancers	Ž	Ž
5.	Heart disease/hypertension, dizziness, swelling	Ž	Ž
6.	Blood disorders (blood clots, etc)	Ž	Ž
7.	Mental illness	Ž	Ž
8.	Autoimmune (RA, MS, Lupus, etc.)	Ž	Ž
9.	Other medical issues (epilepsy, thyroid, liver, etc.)	Ž	Ž

Have you had a history of the following:

		YES	NO
1.	Frequent UTIs	Ž	Ž
2.	Abnormal uterine bleeding	Ž	Ž
3.	Anemia	Ž	Ž
4.	Infectious diseases (hepatitis, jaundice, mono)	Ž	Ž
5.	Blood transfusions	Ž	Ž
6.	Operations/accidents	Ž	Ž
7.	Other medical issues (migraines, frequent cough, SOB, TB, heartburn, bowel, other:______________________________)	Ž	Ž

8. Date of last STD/HIV screening:___/___/____ Ž Never screened
   Diagnosed STDs and treatment dates:__________________________
   ____
9. Date of last PAP smear:___/___/___ Ž Never screened
   Where?____
   Have you ever had an abnormal result? Ž Yes Ž No
   If yes, date and type of treatment:____________________________
10. Do you smoke? Ž Yes Ž No How many cigarettes per day?______
11. Do you drink alcohol? Ž Yes Ž No
    How many alcoholic drinks per day?______ On the weekends?_______
12. What types of street drugs have you used and how often?

Drug	Last Used	How Often	Length of Use

Are you currently experiencing any of the following?

	YES	NO
Persistent sore throat	Ž	Ž
Genital discharge/odor/itching	Ž	Ž
Pain with intercourse	Ž	Ž
Pain in pelvis/lower abdomen/lower back	Ž	Ž
Burning with urination	Ž	Ž
Fever/chilling	Ž	Ž

Lesions: genital Ž non-genital Ž
How long have you had these symptoms?____________________

Have you received:

Gardasil Vaccine Ž Yes Ž No
Hepatitis B Vaccine Ž Yes Ž No

Please list any medications you are taking:
(include any herbal supplements and vitamins)

____
____

Method of birth control________________________

Medication Allergies__________________________

Latex Allergy? Ž Yes Ž No

Menstrual History

1. Onset (age):______________________
2. Days between periods:_______________
3. Length of period:___________________
4. How heavy is your flow?:____________
5. How you have cramping? Ž Yes Ž No
   How severe?_____________________
6. Have you had bleeding between periods?
   Ž Yes Ž No ________________
7. First day of last menstrual period:
   ____
8. Do you think you are pregnant now?
   Ž Yes Ž No

Staff Comments:

Reviewed by:______________________________

Date:__________