Advanced Women's Healthcare Patient Health History

Name: _____ DOB: _____

Current Problem:

_____

_____

_____

Allergies:

_____

_____

_____

Current Medications:

_____

_____

_____

_____

Preferred Pharmacy: _____

Are you menopausal? YES NO If yes, at what age? _____

Have you had a hysterectomy? YES NO If yes, were your ovaries removed? YES NO

Are you sexually active? YES NO

Do you use any form of birth control? YES NO If yes, what kind? _____

Have you ever had a colonoscopy? YES NO If yes, date?_____

Facility performed at? _____

Have you ever had a bone density test? YES NO If yes, date? _____

Facility performed at ? _____

Menstrual History (If you are NOT menopausal)

Are your cycles regular? YES NO

Date of last menstrual period? _____

Pap Smear History

Date of last pap smear: _____ NORMAL ABNORMAL

History of abnormal pap smears? YES NO

Breast:

Ever had a Mammogram? YES NO Date of last Mammogram? _____

History of Abnormal Mammogram? YES NO Facility performed at? _____

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Pregnancy History: Including all miscarriages and/or abortions

#	Date	Sex Of Baby	Weight Of Baby	Weeks' Gestation	Type Of Delivery	Complications: During Pregnancy or During Labor
1						
2						
3						
4						
5						
6						

Personal History Of:

YES	NO		YES	NO	
___	___	Anemia	___	___	High Blood Pressure
___	___	Anxiety	___	___	High Cholesterol
___	___	Asthma	___	___	Hyperthyroidism
___	___	Autoimmune Disorder	___	___	Hypothyroidism
___	___	Blood Clots	___	___	Osteoporosis
___	___	Depression	___	___	Panic Attacks
___	___	Diabetes, Type 1	___	___	Recurrent UTI's
___	___	Diabetes, Type 2	___	___	Sleep Apnea
___	___	Endometriosis	___	___	Stroke
___	___	Fibroids	___	___	Urinary Incontinence
___	___	Glaucoma			

Heart problems? (If yes, please specify) _____

_____

Cancer? (If yes, please list what type) _____

_____

Sexually Transmitted Diseases? (Ever in your life): Gonorrhea Chlamydia Herpes HPV Syphilis HIV None

Please specify any other medical condition you may have that is not listed in the above section:

_____

_____

_____

_____

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Past Surgical History:

_____

_____

_____

Past Hospitalizations:

_____

_____

_____

Family History: List all health issues; cancer, diabetes, heart problems, etc… Please specify

Father: Alive or Deceased _____

Mother: Alive or Deceased_____

Paternal Grandfather: _____

Paternal Grandmother: _____

Maternal Grandfather: _____

Maternal Grandmother: _____

Siblings: _____

Other: _____

Social History:

- Marital Status (circle one) - Single Married Divorced Widowed
- Smoking Status (circle one)- Never a smoker Current smoker Former smoker: Quit in year _____

  If you are a current smoker, how many cigarettes per day?

  ___ 5 or less ___ 6-10 ___ 11-20 ___ 21-30 ___ 31 or more
- Illicit Drug use? YES NO If yes, what type? _____
- Alcohol Consumption - Have you had a drink in the past 12 months? YES NO

  If yes, how often?
  - ___ Monthly or less
  - ___ 2-4 times per month
  - ___ 2-3 times per week
  - ___ 4 or more times per week

  If yes, how many drinks in a typical day?
  - ___ 1 or 2
  - ___ 3 or 4
  - ___ 5 to 6
  - ___ 7 to 8
  - ___ 10 or more
- In a normal day, what is your caffeine intake? _____
- In a normal week, how much exercise do you get? _____

Please complete the back side of this form

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "x" to indicate your answer)

0 = Not at all
1 = Several days
2 = More than half the days
3 = Nearly everyday

	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself-or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐