Advanced Women's Healthcare Patient Health History

Name:_____ DOB:_____

PCP:_____ Pharmacy: _____

Reason for today's visit:

_____

_____

_____

Current Medication

Medication Name	Dose	Taken how often?	Medication Name	Dose	Taken how often?

Allergies

Medication or Product	Reaction	Medication or Product	Reaction

Personal Medical History

	Y	N		Y	N
Anemia	___	___	Glaucoma	___	___
Anxiety	___	___	High Blood Pressure	___	___
Asthma	___	___	High Cholesterol	___	___
Autoimmune Disorder	___	___	Hyperthyroidism	___	___
Blood Clot	___	___	Hypothyroidism	___	___
Depression	___	___	Osteoporosis	___	___
Diabetes, Type I	___	___	Recurrent UTIs	___	___
Diabetes, Type II	___	___	Sleep Apnea	___	___
Endometriosis	___	___	Stroke	___	___
Fibroids	___	___	Urinary Incontinence	___	___

Do you have any history of heart problems? If so, please explain: _____
_____
_____

Do you have any history of cancer? If so, please explain: _____
_____

Please specify any other medical condition not listed above: _____
_____
_____

Please list any surgery you have had and the date(s) of the procedure(s):
_____
_____
_____

Please list any past hospitalization(s) and their date(s) (other than an uncomplicated childbirth):
_____
_____
_____

GYN History

- How old were you when you had your <u>first</u> period? _____
- Are your periods regular? Y N When was the first day of your last period? _____
- Are you postmenopausal? Y N If so, at what age? _____
- Have you had a hysterectomy? Y N
  - If so, were one or both ovaries removed as well? _____
  - If so, was your cervix removed as well? Y N
- Are you sexually active? Y N Sexual orientation: _____
  - Do you use <u>any</u> form of birth control/contraception? Y N
  - If yes, what type: _____ (*Includes condoms, the calendar method, and sterilization, such as tubal ligation or partner's vasectomy.)
  - If not, are you interested in contraception or are you trying to conceive? _____
- Do you have a history of any STIs (circle one)?
  Chlamydia Genital Warts/HPV Gonorrhea Herpes HIV Syphilis None
- When was your last pap smear? _____ Normal or Abnormal
  - Have you ever had an abnormal pap smear? Y N If so, when? _____
  - Have you ever had: Cryotherapy LEEP Laser Therapy Cone Biopsy
    If so, when? _____
- Have you ever had a mammogram? Y N Date: _____ Facility: _____
- Have you ever had a bone density (DEXA) test? Y N Date:_____ Facility: _____
- Have you ever had a colonoscopy? Y N Date: _____ Facility: _____

OB History

(including pregnancy losses or terminations)

	Date of Delivery	M or F	Weight	Weeks Gestation	Type of Delivery	Complications during pregnancy, labor, or delivery (ex. preeclampsia, vacuum assisted, hemorrhage, etc.)
1						
2						
3						
4						
5						
6						

Family History Check here if unknown due to adoption: ☐

Please list all known health conditions (cancers, diabetes, heart conditions, etc).

Father: Living or Deceased _____

Mother: Living or Deceased _____

Paternal Grandfather: _____

Paternal Grandmother: _____

Maternal Grandfather: _____

Maternal Grandmother: _____

Siblings: _____

Other: _____

Social History

- Marital Status (circle one): Single Married Divorced Widowed

- Smoking Status - includes vaping (circle one): Never Current Former (Quit date _____)
  If you are a current smoker:
  - Cigarette use per day (circle one): 5 or less 6-10 11-20 21-30 31 or more
  - One vape cartridge lasts you (circle one): 4 weeks or more 2-4 weeks 1-2 weeks 1-6 days

- Illicit Drug Use (circle one): Never Yes, current use Yes, former use (Quit date _____)
  - If yes, what type: _____

- Alcohol Consumption: Have you had a drink in the past 12 months? No Yes

  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?
  - ☐ 1-2
  - ☐ 3-4
  - ☐ 5-6
  - ☐ 7-8
  - ☐ 9 or more

- On a normal day, how much is your caffeine intake? _____

- In a normal week, how much exercise do you get? _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

0 = Not at all
1 = Several days
2 = More than half the days
3 = Nearly every day
(Please circle your answer)

	Not At All	Several Days	More Than Half The Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3