Female MEDICAL HISTORY INFORMATION SHEET (PLEASE ANSWER ALL QUESTIONS AS THOROUGH AS POSSIBLE)

Name_____

Today's date_____ **Age**_____

Any concerns/issues you would like to discuss today?

GYNECOLOGY HISTORY

First day of last menstrual period?	
Age at 1st period	
# of days between periods (from 1st day of period to 1st day of next period)	
Length of period (# of days of bleeding)	
Heavy bleeding?	Y / N
Cramps?	Y / N

Birth control method ☐ N/A	
Number of sexual partners in last year	
Are you currently sexually active?	Y / N
With whom do you have sex? Males only Both Males and Females	Females only
Have you had any sexually transmitted diseases? If yes, which ones?	Y / N
Would you like to be tested today?	Y / N

When was your last pap smear?	
Any history of abnormal pap smears? When was this? What treatment was performed?	Y / N
When was your last mammogram? ☐ N/A	
Any history of abnormal mammograms?	Y / N
Do you do self-breast exams?	Y / N

Any history of sexual abuse or domestic violence?	Y / N
Do you feel safe in your current relationship?	Y / N
Would you like to talk about this today?	Y / N

If you are in menopause:

When did this begin?	
Which hormone replacement therapy are you taking? ☐ N/A	

What symptoms are you having? Please circle

Hot flashes Vaginal dryness Night sweats

Vaginal bleeding Low libido

Mood changes Difficulty sleeping

OBSTETRIC HISTORY

Please list all previous pregnancies

PAST MEDICAL HISTORY

Please list all medical problems

PAST SURGICAL HISTORY

Please list all previous surgeries

MEDICATIONS

List all medications, **herbs or supplements**

MEDICATION ALLERGIES

SOCIAL HISTORY

Occupation?			
With whom do you live?			
Smoke?	Y/ N	How many packs a day?	
Drink alcohol?	Y/ N	How many drinks a week?	
Do drugs?	Y/ N	Which drugs?	
International travel in the last 6-months?	Y/ N	Where and when	

FAMILY HISTORY

-Please circle if you have any family members with the following:

Breast cancer	Uterine cancer	Ovarian cancer
Colon cancer	Stroke	High blood pressure
Heart attacks	Blood clots	Diabetes
Osteoporosis	Birth defects	High cholesterol

PREVENTATIVE

What kind and how often?

Do you exercise?	Y / N		
Calcium in your diet?	Y / N		
Use sunscreen	Y / N	Seatbelt use?	Y / N

Have you had the following test?		When was this test last done?
Cholesterol	Y / N	
Diabetes screen	Y / N	
Thyroid test	Y / N	
Colonoscopy	Y / N	
Bone density test	Y / N	

REVIEW OF SYSTEMS

- Please circle if you have any of the following:

Fever	Cough
Fatigue	Shortness of breath
Hair loss	Chest pain
Feeling hot/cold	Palpitations
Weight loss/gain	Constipation
Breast pain	Diarrhea
Nipple discharge	Nausea/vomiting
Breast lump	Blood in stools
Pain with urination	Change in height
Blood in urine	Sleep difficulties
Loss of urine/incontinence	Depression or anxiety
Frequent urination	Cuts that don't stop bleeding
Rashes or skin lesions	

NONE OF THE ABOVE