PETERSON
Women's Associates

Name: _____DOB:_____ Today's Date: _____

What would you like to address in today's visit? _____

DO YOU HAVE A PCP (Primary Care Physician)? NO YES _____

The health history questionnaire you are about to fill out is important. It gives us information about your health, which will enable us to spend time discussing your medical condition. It will become part of your medical record and will remain confidential.

SOCIAL HISTORY:

Do you currently smoke cigarettes? No, never Yes Date started: _____
Amt/PPD: _____ Quit Stop Date: _____
Do you drink alcohol and if so, how often? No, never Yes How often: _____
Have you ever used IV drugs? No, never Yes Past Stop Date: _____ Current
Do you have a history of drug abuse? No, never Yes Past Stop Date: _____ Current
Have you ever been physically abused? No, never Yes Past Current

EXERCISE & DIET:

Do you exercise and if so, how often? Regularly Occasionally Rarely Never
Do you drink caffeine and if so, how often? Regularly Occasionally Rarely Never

SEXUAL HISTORY:

Have you ever been sexually active? No Yes If yes, are you currently? No Yes
Do you or your partner have more than one partner? No Yes
Are your partner(s) Male Female Both
Do you have concerns about sexually transmitted infections? No Yes Unsure
Would you like to be tested for sexually transmitted infections? No Yes Unsure
Have you had a sexually transmitted infection? No Yes
If yes, which one(s)? Chlamydia Genital Herpes Gonorrhea Genital Warts Syphilis HIV/AIDs
Were you treated? No Yes Unsure What year was it? _____
Do you have any concerns about sex? No Yes Unsure
What method of birth control, if any, are you using? _____

SCREENING TEST: Have you had any of the following tests?

Blood Test: No Yes Date: _____
Colonoscopy: No Yes Date: _____
Bone Density (Dexa Screening): No Yes Date: _____ and Facility: _____

MENSTRUAL HISTORY:

At what age did you have your first period: _____

Are your menstrual periods: Regular Irregular

How many days is your period? _____ Is your flow: Light Moderate Heavy

How many days are between your periods? _____

Do you have spotting or bleeding between periods? No Yes

Do you have menstrual pain/cramping? No Mild Moderate Severe

What medications do you take for this? _____

What was the first day of your last period? _____

IF POST-MENOPAUSAL:

At what age did your periods stop? _____

Are you experiencing any vaginal bleeding? No Yes

Do you use hormones? No Yes If yes: **Systemic** Current Past **Vaginal** Current Past

GYNECOLOGIC HISTORY:

Have you ever had a pap smear? No Yes Date: _____ Results: Normal Abnormal

Have you had treatment for abnormal pap smears? No Yes Unsure

What type(s) of treatment have you had? LEEP Colposcopy Cone Biopsy Cryotherapy

Have you had a mammogram: No Yes Date: _____ Was it abnormal? No Yes

Have you had any of the following:

Ovarian Cyst	Fibroids	Infertility
Polycystic ovaries	Endometriosis	Abnormal uterine structure

PREGNANCY HISTORY: (all pregnancies including abortions & ectopic)

Have you ever been pregnant? No Yes Number of pregnancies: _____

Number of children: _____ Number of abortions: _____ Number of miscarriages: _____

Date of Delivery	Male Female	Weeks Gestation	Birth Weight	Anesthesia (epidural/IV)	Delivery (vaginal /c-sec)	Complications During pregnancy	Place of delivery

Under complications please be specific: Premature Labor, Still Born, Birth Defects, High Blood Pressure, Kidney Infection, Diabetes.

MEDICAL HISTORY:

Do you have any major medical problems? No yes: _____

Please indicate which family member or self has a history of:

Self **M**-Mother **F**-Father **S**-Sister **B**-Brother

MGM-Maternal Grandmother **MGF**-Maternal Grandfather **PGM**-Paternal Grandmother

PGF-Paternal Grandfather

Anemia	Self	M	F	S	B	MGM	MGF	PGM	PGF
Anesthetic complications	Self	M	F	S	B	MGM	MGF	PGM	PGF
Arthritis or Lupus	Self	M	F	S	B	MGM	MGF	PGM	PGF
Blood Clotting Disorder (Phlebitis)	Self	M	F	S	B	MGM	MGF	PGM	PGF
Depression or Psychiatric Disorders	Self	M	F	S	B	MGM	MGF	PGM	PGF
Diabetes	Self	M	F	S	B	MGM	MGF	PGM	PGF
Drug addiction	Self	M	F	S	B	MGM	MGF	PGM	PGF
Frequent infections	Self	M	F	S	B	MGM	MGF	PGM	PGF
Gallbladder disease	Self	M	F	S	B	MGM	MGF	PGM	PGF
Heart attack or angina	Self	M	F	S	B	MGM	MGF	PGM	PGF
Heart disease	Self	M	F	S	B	MGM	MGF	PGM	PGF
Hepatitis/jaundice	Self	M	F	S	B	MGM	MGF	PGM	PGF
High blood pressure	Self	M	F	S	B	MGM	MGF	PGM	PGF
High cholesterol	Self	M	F	S	B	MGM	MGF	PGM	PGF
History of Blood transfusion	Self	M	F	S	B	MGM	MGF	PGM	PGF
Kidney stones or disease	Self	M	F	S	B	MGM	MGF	PGM	PGF
Migraine Headaches	Self	M	F	S	B	MGM	MGF	PGM	PGF
Neurological disorders	Self	M	F	S	B	MGM	MGF	PGM	PGF
Osteoporosis	Self	M	F	S	B	MGM	MGF	PGM	PGF
Pulmonary embolus	Self	M	F	S	B	MGM	MGF	PGM	PGF
Seizures	Self	M	F	S	B	MGM	MGF	PGM	PGF
Sickle cell trait	Self	M	F	S	B	MGM	MGF	PGM	PGF
Stomach or Bowel Disorders	Self	M	F	S	B	MGM	MGF	PGM	PGF
Stroke	Self	M	F	S	B	MGM	MGF	PGM	PGF
Thyroid disease	Self	M	F	S	B	MGM	MGF	PGM	PGF
Ulcers	Self	M	F	S	B	MGM	MGF	PGM	PGF

Cancer: Colorectal, Endometrial, Gastric, Ovarian, Pancreatic, Ureter, Renal Pelvis, Biliary Tract, Brain, Small Intestine, Sebaceous Gland Adenomas

For Cancer please circle and indicate which family member.

If there is any diagnosis that is not listed please list here: _____

_____

ALLERGIES:

Please note any allergies or reactions to medications or other agents. **None**

Medication: _____Reaction:_____

Medication: _____Reaction:_____

SURGICAL HISTORY: (Please list type and year)

_____

_____

_____

_____

CURRENT PRESCRIPTION MEDICATIONS:

Please list PRESCRIPTION medications you currently take including DOSAGE AND INSTRUCTIONS.

None

Med/Dose/Instructions:

_____

Med/Dose/Instructions:

_____

Med/Dose/Instructions:

_____

Please list any non-prescription medications, supplements and/or herbal remedies you take:

_____

REVIEW OF SYSTEMS:

Are you currently having problems with:

Fatigue	Heat or cold intolerance	Involuntary loss of urine
Weight loss	Excess hair growth	Abnormal vaginal discharge
Weight gain	Excessive hair loss	Varicose veins
Easy bruising	Skin moles	Breast pain
Enlarged glands or lumps	Abdominal pain	Breast discharge
Hot flashes	Painful urination	Breast lump

Please list any additional information you would like us to know:

_____

_____

_____

_____