

HealthCare for Women

Patient Name: _____

PAST HISTORY: Check if you have ever had any of the following:

<input type="checkbox"/> Tumor of any kind	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Anemia
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hernia	<input type="checkbox"/> Blood Disease
<input type="checkbox"/> Infection	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Bleeding Problem
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Other Rectal problems	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Serious Head Injury	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Frequent or Severe Headaches	<input type="checkbox"/> Rapid or Irregular Heartbeat	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Fainting spells	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Kidney Infection
<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Frequent or Severe abdominal pain	<input type="checkbox"/> Bladder Infection
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Frequent or Severe indigestion	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Chronic or Recurrent Diarrhea	<input type="checkbox"/> Mental Disease
<input type="checkbox"/> Red Measles	<input type="checkbox"/> Ulcer of Stomach or Duodenum	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Mumps	<input type="checkbox"/> Gall Bladder Trouble	<input type="checkbox"/> Thyroid Infection
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Yellow Jaundice or Hepatitis	<input type="checkbox"/> Serious Injuries
<input type="checkbox"/> German Measles (3 day)	<input type="checkbox"/> Chronic Constipation	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Polio	<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Varicose Veins or Phlebitis
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Asthma	<input type="checkbox"/> Other

Do you have allergies? _____ Have you ever received blood? _____

HAVE YOU EVER HAD AN OPERATION ON ANY OF THE FOLLOWING? CHECK (X) IF YES:

<input type="checkbox"/> Appendix	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Fallopian Tubes
<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Chest	<input type="checkbox"/> Uterus
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Spine	<input type="checkbox"/> Vaginal Repair
<input type="checkbox"/> Tonsils	<input type="checkbox"/> Breast	<input type="checkbox"/> Cesarean Section
<input type="checkbox"/> Tumor of any kind	<input type="checkbox"/> Ovary	<input type="checkbox"/> Other
<input type="checkbox"/> Hernia	<input type="checkbox"/> D & C	<input type="checkbox"/>

FAMILY HISTORY:

Have your grandparents, parents, uncles, aunts, brothers, sisters or children ever had any of the following?

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Nervous Breakdown
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Blood Disease
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hay Fever or Asthma	<input type="checkbox"/> Muscular Disorders

Patient Name: _____

SOCIAL AND PERSONAL HISTORY:

1. <input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced	Number of years: _____		
2. Married more than once:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How many times: _____				
3. Do you use alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
4. Do you take any medicine regularly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
5. Do you now use some method of birth control?	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Check method used:	<input type="checkbox"/> IUD	<input type="checkbox"/> Pill	<input type="checkbox"/> Diaphragm	<input type="checkbox"/> Condom	<input type="checkbox"/> Rhythm	<input type="checkbox"/> Withdrawal	<input type="checkbox"/> Other
Frequency used:	<input type="checkbox"/> Used Always	<input type="checkbox"/> Used Most of the time	<input type="checkbox"/> Used some of the time				

MENSTRUAL HISTORY:

1. Age at first menstrual period _____		
2. Do you menstruate now?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Periods are:	<input type="checkbox"/> Regular	<input type="checkbox"/> Irregular
4. Approximately how many days from the beginning of one period to the beginning of the next? _____		
5. Periods usually last for a total of _____ days.		
6. Do you ever have bleeding or spotting between periods?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you ever had a pap smear?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Have you missed any periods without being pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Have you missed any periods at this time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Was your last period normal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Date last period began: _____	Date period before that began: _____	

OBSTETRICAL HISTORY:

1. How many times have you been pregnant?	_____	
2. How many full-term (9 month) babies have you had?	_____	
3. How many premature babies have you had?	_____	
4. How many miscarriages have you had?	_____	
5. How many living children do you have?	_____	
6. Have any of your babies been jaundiced after birth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have all your children been normal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Were any of your pregnancies complicated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Oldest child's age: _____	Youngest child's age: _____	