women's & men's health services of the Coastal Bend, Inc.

FEMALE HEALTH HISTORY

Date ____/____/____ NAME_____ DOB ____/____/____ AGE____

Yes No

___ ___ Are you allergic to any medications, latex, foods, products, or anesthesia? List:_____

___ ___ Are you currently taking medications (include herbal remedies, vitamins, over-the-counter medication) List:_____

___ ___ Do you have a primary care provider or other doctor? Reason? _____ Name ? _____

FAMILY HISTORY

Are you adopted? Yes___ No____

Have your biological family (parents, brothers, sisters) had any of the following?

Yes	No		Who?
___	___	High cholesterol	_____
___	___	Diabetes	_____
___	___	High blood pressure	_____
___	___	Cancer	_____
___	___	Heart Attack/stroke before age 55	_____
___	___	Sickle cell anemia/trait	_____
___	___	Genetic problems?	_____
___	___	Other	_____

PAST MEDICAL HISTORY (Please check all that apply now or in the past.)

Yes	No	
___	___	Blood transfusions
___	___	Heart disease/Murmurs/Valves
___	___	Chest pain or shortness of breath
___	___	High blood pressure
___	___	Stroke
___	___	Blood clots or clotting disorder (such as hemophilia)
___	___	Varicose veins or inflammation of veins
___	___	Scarlet or rheumatic fever
___	___	High cholesterol / triglycerides/ blood fats
___	___	Anemia/Low iron
___	___	Sickle Cell disease
___	___	Depression
___	___	Anxiety or other psychological problems
___	___	Psychiatric treatment
___	___	Lupus/rheumatoid arthritis
___	___	Migraine headaches
___	___	Frequent headaches
___	___	Cancer
___	___	Seizures or epilepsy
___	___	Liver disease, hepatitis, jaundice, mononucleosis
___	___	Gall bladder problems
___	___	Thyroid problems
___	___	Diabetes/gestational/pre-diabetes
___	___	Birth defects, genetic problems

Yes	No	
___	___	Stomach or bowel problems
___	___	Asthma, chronic cough or breathing problems
___	___	Sleep apnea
___	___	Skin allergies or irritation
___	___	TB or other lung disease
___	___	Eye problems (not if just glasses or contacts)
___	___	Hearing problems
___	___	Major dental problems
___	___	Frequent nosebleeds or sore throats
___	___	Arthritis, osteoporosis
___	___	Acne or other skin problems
___	___	Exposure to work-related hazards or environmental toxins

Past Gyn History

___	___	Uterine fibroids
___	___	Ovarian cysts
___	___	Breast surgery
___	___	Endometriosis
___	___	Chlamydia _____
___	___	Gonorrhea _____
___	___	Syphilis _____
___	___	Herpes _____
___	___	Warts/HPV _____
___	___	HIV _____
___	___	Pain with sex? Other sex problems?
___	___	**Previous abnormal pap?** When_____

Are you up-to-date on immunizations (shots) DPT, Rubella, Measles, Meningitis, hepatitis, polio? Yes___ No___ HPV? Yes___ No___

Do you have any of the following symptoms?

Yes	No		Yes	No		Yes	No	
___	___	Numbness of arms or legs	___	___	Genital Warts	___	___	Rash
___	___	Night sweats	___	___	Abdominal Pain	___	___	Breast pain, lump, tumor, discharge
___	___	Fever/chills	___	___	Sores	___	___	Vaginal discharge that itches, burns or has bad odor
___	___	Swollen Glands	___	___	Itch	___	___	Bladder, urine leaks or frequent urinary tract infections
___	___	Chronic fatigue > 6 months	___	___	Hot flashes	___	___	Pain when urinating
___	___	Unexplained weight gain or loss	List any self-treatment for any of the above symptoms_____					

List any surgeries, severe illnesses, injuries or other medical conditions you have had or have now and approximate date:

_____

Are you planning any major surgery requiring long term bed rest? Yes___ No____

Pregnancy History never pregnant ☐

Delivered			**Abortion/Miscarriage**			
Year	Month	Vaginal or C Section	Year	# Weeks	Spont.	Induced

Menstrual History

Age periods began_____ Are your periods regular? Yes___ No___ Length of period ___ days. # of days between periods?_____
Last period started on _____ Was it Normal? Yes____ No___
Do you have vaginal bleeding between menstrual periods? Yes____ No____
Do you have vaginal bleeding after sex Yes____ No____
With your period do you have: bloating____ bowel problems_____ Emotional problems____

Contraceptive History/Reproductive Life Plan :

Are you planning a pregnancy in the next year? Yes___ No___
Current birth control method? _____ How long used?_____
Any problems with this method? Yes____ No____ If yes, what_____
Do you want to switch methods Yes___ No___ To what_____
Which of the following methods have you used in the past (check all that apply)
IUD____ Nexplanon____ Depo Provera (shot)____ The Pill____ The Patch____ Condoms____ Diaphragm_____
Sponge_____ Spermicide_____ Rhythm Method_____ Natural Family Planning_____ Withdrawal (pulling out)_____
Please comment on what you did or did not like about previous methods_____

STD/HIV RISK ASSESSMENT

Date of last sexual encounter?_____
Number of sex partners in past year? _____ Number of partners in your life? Women_____ Men____
Were any of your partners a hemophiliac? Yes___ No___ Infected with HIV/AIDS? Yes___ No___ A street drug user? Yes___ No___
Have you ever shared needles? (drugs, tattooing, piercing)? Yes____ No___
Any partners test positive for STI? Yes___ No___ If yes, what?_____

Health Habits (All health information is confidential and cannot be released without your permission except abuse of a minor which we must report to authorities)

Yes No

___ ___Do you exercise regularly?
___ ___Do you consider your diet and eating habits healthy?
___ ___Do you smoke or vape? Number a day?_____ For how long?_____
___ ___Do you use other forms of tobacco?
___ ___Do you drink alcohol excessively?
___ ___Do you use drugs (marijuana, cocaine, etc)?
___ ___Have you ever used IV drugs?
___ ___Are others concerned with your alcohol and/or drug habits?
___ ___Have you been physically or sexually abused?
___ ___Are you afraid of your partner(s) or a family member?
___ ___ Is someone forcing or coercing you to have sex?

Staff comments (do not write in this space)

Who helps and supports you with your problems?_____

What questions can we answer for you today?_____

To the best of my knowledge the information I have provided is correct and complete.

Patient Signature_____ Date_____ Staff Signature_____ Date_____

History Reviewed:
Clinician Signature _____ Date_____

Clinician Signature_____ Date_____