Wake Women's Health

New Patient Health History Form

Name:_____Birth date:_____Primary care doctor:_____

Reason for today's visit/concerns? □Annual _____

Date of 1st day of last menstrual period:
Age at first period:
If you are in menopause, when did your periods stop? If you still have periods**:** Periods occur every _____ days, last for _____days

PREGNANCY HISTORY: Have you ever been pregnant? □Yes □No Do you think you could be pregnant today? □Yes □No

_____Total # of pregnancies	_____Vaginal births	_____Cesarean sections
_____Miscarriages	_____Abortions	_____ Ectopic (tubal) pregnancy

Child(s) names:

List any pregnancy complications (such as high blood pressure, gestational diabetes):

SEXUAL HISTORY

Have you ever had intercourse? □Yes □No

Are you currently sexually active? □Yes □No
If so, do you have a: Male partner? □Yes □No Female partner? □Yes □No Both? □Yes □No

I am: Single Married Divorced Widowed How long have you been with your current partner?

Any pain with sexual activity? □Yes □No

Have you ever experienced sexual abuse or violence? □Yes □No

Do you feel threatened or unsafe in your personal relationships? □Yes □No

What type of birth control are you **currently** using?

What type of birth control have you used <u>in the past</u> (circle all)?

- Condoms Pills IUD Implant (Nexplanon) NuvaRing
- DepoProvera Tubal ligation Vasectomy Patch
- Natural family planning/withdrawal ESSURE Other

Do you currently have any of the following:

□ Heavy periods, irregularity, spotting, or pain with periods
□ Bloating, irritability, or other symptoms at or around time of period
□ Hot flashes or night sweats
□ Endometriosis
□ Uterine fibroids
□ Ovarian cysts/tumors

PREVENTATIVE SCREENING	
When was your last Pap smear?	
When was your last mammogram?	
When was your last colonoscopy?	
When was your last bone density scan?	

Wake Women's Health

Have you ever had:		If yes, when?
An abnormal Pap smear?	□Yes □No	
A colposcopy for an abnormal Pap?	□Yes □No	
Cryosurgery, cone biopsy, or a LEEP?	□Yes □No	
Were you ever exposed to DES?	□Yes □No	
Did you receive the HPV/Gardasil vaccines?	□Yes □No	
A sexually transmitted disease?	□Yes □No	
If yes, which ones? □ Gonorrhea □ Chlamydia □ Syphilis □ Genital Herpes □ Genital Warts □ PID/other STDs		

Personal Medical History (Place an **X** in the boxes that apply):				
□Cancer:		□Blood clots in the legs (DVT) or lungs (pulmonary embolism)		
□Diabetes	□Stroke	□Thyroid disease	□Migraines	□Anemia
□High blood pressure	□High Cholesterol	□Heart attack	□Heart murmur	□Rheumatic fever
□Artificial heart valve	□Other heart problems:			
□Asthma	□Other lung problems:			
□ Fibrocystic breasts	□Breast implants	□Breast masses	□Other breast problems	
□Reflux/heartburn	□Hiatal hernia	□Ulcers	□Gallbladder disease	
□Kidney disease	□Kidney stones	□Recurrent urinary tract infections (>3/year)		□Incontinence
□Hepatitis	□Liver disease:			
□Blood disease	□Sickle cell anemia	□Clotting problems/von Willebrand's		
□Depression	□anxiety	□Other mental health problem:		
□Autoimmune disease (such as lupus)				
□Arthritis	□joint pain	□back problems	□Osteoporosis	
□Other medical problems not listed above and any hospitalizations:				

Wake Women's Health

Surgical History Have you ever had complications with anesthesia? □Yes □ No

Have you ever had a blood transfusion? □Yes □ No

Year	Surgery	Year	Surgery

FAMILY HISTORY:

Are you of Ashkenazi Jewish descent? □Yes □No □Don't know

Have you or any member of your family had genetic testing for hereditary cancer? □Yes □ No □Don't know

List family members with the following cancers: include parents, children, siblings, grandparents, aunts, uncles, & cousins

	Mother's side	Age at diagnosis	**Father's side**	Age at diagnosis	**Your siblings**	Age at diagnosis
Breast Cancer						
Ovarian cancer						
Uterine cancer						
Colon Cancer						
OTHER cancers:						

PLEASE LIST ANY MEDICAL OTHER CONDITIONS IN YOUR FAMILY (such as heart attacks, strokes, clotting disorders):

SOCIAL HISTORY	
Current job/profession:	Where employed:
Do you use tobacco? □Yes □No □Quit, when:	Number of packs/day:
Do you use recreational or street drugs? □Yes □ No	
Alcohol How many drinks of alcohol per day?	
Caffeine □ # of cups/cans per day?	
Exercise: □ Sedentary (No exercise) □ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) □ Occasional vigorous exercise (<4x/week) □ Regular vigorous exercise (4x/week)	
Seatbelt use: □Always □Most of the time □Rarely □Never	
Sun exposure: □Rarely □Occasional □Frequent	

Wake Women's Health

Current medications (including over-the-counter drugs, vitamins & herbals)

Name	Strength	Taken how often

Please list any allergies you have:

Allergen	Reaction	Allergen	Reaction

REVIEW OF SYSTEMS: Please mark an "X" if you <u>currently</u> have:	
GENERAL	□Fevers □Chills □Night sweats □Fatigue □Unintended weight loss/gain
EYES	□Visual changes □Double vision □ Blind spots □Eye pain
EARS, NOSE, MOUTH & THROAT	□ Frequent nose bleeds □Ringing in ears □Ear pain/discharge □Hearing loss □ Bleeding in gums □ Sore throat □Difficulty swallowing □ Sinus pain □ Dentures
CARDIOVASCULAR	□ Chest pain with exercise □ Shortness of breath □ Palpitations □ Feeling faint
RESPIRATORY	□ Cough □Wheeze □Blood in sputum
GASTROINTESTINAL	□ Severe abdominal pain □ Decreased appetite □New abdominal bloating □Bloody stools □ Nausea/vomiting □Vomiting blood □Diarrhea □Constipation □Change in bowel habits □ Accidental loss of stool or gas
URINARY	□ Pain with urination □ Accidental loss of urine □ Blood in urine □ Frequent nighttime urination
MUSCULOSKELETAL	□New muscle or joint pain □Limb weakness or paralysis □Joint swelling
SKIN	□ Skin rash □New mole
NEURO	□New headaches □ Dizziness □ Seizures □Numbness in extremities □Tremors
PSYCH	□Serious depressed mood □Excess anxiety □ Thoughts of hurting self □Hallucinations
BREAST	□Breast pain □New lump □ Nipple discharge □Skin changes
ENDOCRINE	□Cold intolerance □Heat intolerance □Excess thirst
HEMATOLOGIC	□ Anemia □Abnormal bruising or bleeding □Enlarged lymph nodes
IMMUNOLOGIC	□Hay fever □Persistent Infections □HIV exposure