



MEDICAL HISTORY – WOMEN'S HEALTH

Affix Label Here

Today's Date: ____ / ____ / ____

Last Name: _____ First Name: _____

PSUID: _____ DOB: ____ / ____ / ____
Mo. Day Year

Please complete for your first Women's Health visit at University Health Services. This form is confidential. PLEASE USE BLACK INK. Please note yes or no answers with a check [✓]. Do you currently or have you ever had any of the following conditions?

PAST MEDICAL HISTORY:

- | Yes | No | |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Significant depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Migraine headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood clot or vein problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis or liver disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast lump/disease |

GYNECOLOGICAL HISTORY:

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Severe menstrual cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal pap |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis |
| <input type="checkbox"/> | <input type="checkbox"/> | PID (pelvic infection) |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted infection |
| | | If yes, indicate: |
| | | <input type="checkbox"/> HPV (warts or cervical), <input type="checkbox"/> HIV |
| | | <input type="checkbox"/> Herpes (genital), <input type="checkbox"/> Gonorrhea |
| | | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> | <input type="checkbox"/> | Other significant gynecologic history: |
| | | <i>If yes, explain:</i> _____ |

OTHER SIGNIFICANT PAST MEDICAL HISTORY:

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Hospitalizations |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgeries |
| <input type="checkbox"/> | <input type="checkbox"/> | Other significant chronic illness, such as gallbladder disease, sickle cell disease, asthma, eating disorder: |
| | | <i>If yes, explain:</i> _____ |

None

FAMILY HISTORY:

Has anyone in your immediate family (MOTHER, FATHER, SISTER, or BROTHER) had any of the following?

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Breast Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Colon Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Ovarian Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure, stroke, blood clots, or heart attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Major depression, drug or alcohol problem |

Please explain any "Yes" responses to the family history questions above:

SOCIAL HISTORY:

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use tobacco? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you or have you been sexually active? |
| | | Gender of partner(s) ____Male ____Female ____Both |

If applies, age at first intercourse? ____ (pertinent to assess cervical cancer risk)

OTHER:

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been pregnant? If yes, # of times ____. |
|--------------------------|--------------------------|---|

For this visit:

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Is this your first pelvic exam? |
| <input type="checkbox"/> | <input type="checkbox"/> | Will you be requesting a contraceptive method at this time? |

Patient signature

Provider signature