Triad Women's Health and Wellness Center

NAME:
DATE OF BIRTH:
TODAY'S DATE:

CONFIDENTIAL HISTORY
INITIAL VISIT

Please answer all questions on this form. Circle Yes, No or the correct response **and** fill in the blanks as requested.

GENERAL HEALTH AND SAFETY

Do you wear a seat belt?	**Yes**	**No**	
Do you smoke? Have you ever smoked?	**No**	**Yes**	**If yes, how much? How Long?**
Do you drink alcohol?	**No**	**Yes**	**If yes, how many drinks per week?**
Do you use street drugs?	**No**	**Yes**	**If yes, which drug(s)?_____ How often?**
Do you exercise regularly?	**Yes**	**No**	**Type of exercise? _____ How long at a time?_____ How many times per week?**
Do you perform a monthly breast self-exam?	**Yes**	**No**	**Comment:**
Are you currently in a safe, non-violent relationship?	**Yes**	**No**	**Comment:**
Have you ever had an unsafe or violent relationship?	**No**	**Yes**	**Comment:**
Do you have a history of sexual abuse?	**No**	**Yes**	**Comment:**

GYNECOLOGIC AND BREAST HISTORY

What is the date of your last menstrual period?	**Date:**				
How old were you when you had your first period?	**Age:**				
How often do you have a period?					
How many days does it last?					
Are your periods regular?	**Yes**	**No**	**Comment:**		
Have your periods changed in the last year?	**Yes**	**No**	**If yes, how?**		
How would describe your menstrual flow? (circle response)	**Light**		**Moderate**		**Heavy**

When was your last Pap Test?	**Date:**			
Was your last Pap Test normal?	**Yes**	**No**	**Don't Know**	
Have you ever been treated for an abnormal Pap Test?	**Cryo**	**Laser**	**LEEP**	**Other**
When?	**What treatment received?**			

Have you ever had a mammogram?	**Yes**	**No**	**Date of Last Mammogram:**
What was the result of the mammogram?			

Are you sexually active?	**Yes**		**No**		
How many sexual partners have you had in the past year?					
What type(s) of birth control do you use now?	**None**	**Pills**	**Diaphragm**	**Foam/Gel**	**Depo**
What type(s) of birth control have you used in the past?					
Do you use condoms?	**Yes**		**No**		
Have you had your tubes tied?	**Yes**		**No**		
Has your husband or partner had a vasectomy?	**Yes**		**No**		

OBSTETRIC HISTORY

Are you currently trying to get pregnant?	**Yes**	**No**
Are you planning to try to get pregnant in the next year?	**Yes**	**No**
Total number of times you have been pregnant?	Number of living children:	
Number of vaginal deliveries:	Number of cesarean sections:	
Number of miscarriages:	Number of abortions:	
Please list any pregnancy complications?		

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DATE OF BIRTH: ____/ _____/ _____
TODAY'S DATE: ____/ _____/ _____

HISTORY AND CONCERNS
Do you have a history of any of the following conditions? If you have concerns and would like to discuss any of these topics, please circle the word "Discuss".

Syphilis	Yes	No	Discuss	Painful periods	Yes	No	Discuss
Gonorrhea or chlamydia	Yes	No	Discuss	Bleeding between periods	Yes	No	Discuss
Herpes	Yes	No	Discuss	Abnormal vaginal discharge	Yes	No	Discuss
HIV or AIDS	Yes	No	Discuss	Frequent vaginal infections	Yes	No	Discuss
Genital warts	Yes	No	Discuss	Frequent bladder infections	Yes	No	Discuss
Pelvic infection/PID	Yes	No	Discuss	Endometriosis	Yes	No	Discuss
Pelvic pain/pressure	Yes	No	Discuss	Fibroids	Yes	No	Discuss
Pain with intercourse	Yes	No	Discuss	Ovarian cysts	Yes	No	Discuss
Bleeding with intercourse	Yes	No	Discuss	Lumps, bumps, blisters in vaginal area	Yes	No	Discuss
Vaginal dryness	Yes	No	Discuss	Urine or stool leakage	Yes	No	Discuss
Hot flashes/night sweats	Yes	No	Discuss	Other	Yes	No	Discuss

PERSONAL PAST MEDICAL HISTORY

ILLNESSES/CONDITIONS (Diabetes, heart disease, cancer, etc)	**MEDICATIONS** (All current prescriptions AND over-the-counter drugs, supplements, herbs you are taking)	
1.	1.	6.
2.	2.	7.
3.	3.	8.
4.	4.	9.
5.	5.	10.

ALLERGIES/REACTIONS	**SURGERIES/OPERATIONS**	
1.	1.	Year:
2.	2.	Year:
3.	3.	Year:
4.	4.	Year:
5.	5.	Year:

IMMUNIZATIONS				
Tetanus	Yes	No	Date:	Comment:
Hepatitis B	Yes	No	Date:	Comment:
Measles/Mumps/Rubella	Yes	No	Date:	Comment:
Chicken Pox	Yes	No	Date:	Comment:

FAMILY MEDICAL HISTORY

Diabetes	Yes	No	Mother	Father	Sister	Brother	Other:
Heart Disease	Yes	No	Mother	Father	Sister	Brother	Other:
High Blood Pressure	Yes	No	Mother	Father	Sister	Brother	Other:
Cancer	Yes	No	Mother	Father	Sister	Brother	Other:
Type of Cancer							
Approximate age of dx							
Tuberculosis (TB)	Yes	No	Mother	Father	Sister	Brother	Other:
Other Conditions in Family:							

Patient Signature: _____ Date:_____

Physician Signature: _____ Date:_____