All Women's Health PS

Medical and Contraceptive History

Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____ Occupation: _____
Address: _____
City: _____ State: _____ Zip: _____ County: _____
Phone: _____ Alternate Phone: _____
Have you ever been a patient here before? Yes ☐ No ☐
If no, how did you hear about us? _____

Today's Visit

Reason for Visit Today : _____
Any concerns you would like to discuss with the doctor : _____
_____

Gynecology History

Have you had:

Yes	No		When?	Yes	No		When?
☐	☐	Annual pap test	_____	☐	☐	Surgery on your uterus or cervix	_____
☐	☐	Abnormal pap test	_____	☐	☐	Syphilis	_____
☐	☐	Chlamydia	_____	☐	☐	Trichomoniasis	_____
☐	☐	Genital warts	_____	☐	☐	Yeast infection	_____
☐	☐	Gonorrhea	_____	☐	☐	Bacterial Vaginosis	_____
☐	☐	Herpes	_____	☐	☐	PID	_____

Menstrual History

Date last period began: _____ Was it normal? Y N
Are your periods: ☐ regular ☐ irregular?

Social History

Do you smoke tobacco? Y N Are you using recreational drugs? Y N

Demographic Information

Race: ☐ White ☐ Black/African American ☐ American Indian ☐ Asian
☐ Hispanic ☐ Other _____

Pregnancy History

Age at first pregnancy: _____ Total number of times pregnant: _____
Year of last pregnancy: _____ Years of past pregnancies: _____
# of children _____ # of cesarean sections: _____
# of ectopics: _____ # of miscarriages _____
# of abortions (not including today): _____ # of still births: _____
Are you currently breast feeding? _____
Have you had complications with any birth abortion, miscarriage, or cesarean section? Y N

Contraceptive History

What birth control have you taken in the past?

- ☐ Oral contraceptives (birth control pills)
- ☐ Depo Provera (3 month injection)
- ☐ Ortho Evra (the patch)
- ☐ Plan B (emergency contraception)
- ☐ IUD
- ☐ Nuvaring
- ☐ Vasectomy
- ☐ Condom
- ☐ Other

What birth control are you currently using? _____

What are you interested in now? _____

Medical History

List any allergies to drugs or seafood: _____

Any medical problems (now or in past): _____

_____

Any surgeries: _____

_____

Do you take any medications? (circle one) Yes No

List: _____

Are there any medical problems in your family history? _____

_____

Sexual History

Current marital status: _____

Are you currently sexually active?	Yes	No	
Do you currently partner with	☐ men	☐ women	☐ both?
In the past, did you partner with	☐ men	☐ women	☐ both?

Have you:

Used Condoms with all new partners?	Y	N
Had two or more sex partners in the last 60 days?	Y	N
Had a new sex partner in the last 60 days?	Y	N
Had a partner with symptoms or infection in the last 60 days?	Y	N
Had any sexually transmitted infections in the last 12 months?	Y	N

Are there any concerns about sexuality, sexual assault, rape, drugs/alcohol, or domestic violence you would like information about or to discuss with the doctor? Please circle any areas you would like more information about and/or describe below.

_____

I certify that the medical information above is true and accurate to the best of my knowledge.

_____ _____

Signature Today's Date

(For office use only)

Medical History Reviewed: _____ _____

Physician Date