WOMEN'S CARE COMPREHENSIVE HISTORY (PAGE 1)

Name	Date of Visit
Date of birth Age	Physician/CNM
Social Security Number	

Reason for visit

Allergies (Drug and Food or Latex Allergies)

Drug or Substance		Reaction

Medications (Prescribed Medications, Herbs, Vitamins and Over the Counter)

Name	Dose(i.e. mg)	Times you take this medication (i.e. Twice a day)

Diagnostics	Date	Result	
Last Pap Smear		Normal/ Abnormal	Other: List test and result
Mammogram		Normal/ Abnormal	
Bone Density		Normal/ Abnormal	
Lipid Panel		Normal/ Abnormal	
Thyroid testing		Normal/ Abnormal	
Colonoscopy		Normal/ Abnormal	

Contraception Current _____ Past _____

GYN History Date of last menstrual cycle? _____ Age of first menses _____

Have you ever taken hormone replacement therapy? YES / NO What? _____ How long? _____

Do you have a history of abnormal Pap Smears? YES/ NO When_____

If Yes, was treatment necessary? YES/ NO Type of treatment Antibiotic Cream/ Cryosurgery (freezing) Laser / Leep / Cone Biopsy /

Do you have a history of sexually transmitted diseases? YES/ NO

Type Chlamydia/ Genital warts/ Gonorrhea/ HPV (Human papilloma virus)/ PID (Pelvic inflammatory disease) Syphilis/ Trichimonas/ Herpes / Other _____

Have you received the Gardasil (HPV) vaccine? YES/ NO How many doses?_____

Have you ever taken fertility medications? YES/ NO Type _____

Do you have a history of endometriosis? YES/ NO Treatment _____

(At Appointment)

Nursing Documentation RN/MA _____

Weight _____ Height _____ Blood Pressure _____ Nurse for Exam Yes/No

Patient Name _____
DOB _____

WOMEN'S CARE COMPREHENSIVE HISTORY (PAGE 2)

Pregnancies Including current	Full Term Deliveries	Premature	Elective Abortion	Miscarriage/ Spon Ab	Ectopic	Multiple Births	Living Children

Past Pregnancies

Date Month/Year	Weeks of Gestation	Length of Labor	Birth Weight	Sex Male/Female	Type of Delivery	Preterm Labor Yes/No	Complications

If you have had an ectopic pregnancy, did you require surgery? YES / NO
Did you have an Ovary or Fallopian tube removed? YES / NO If yes, which one? _____

WOMEN'S CARE COMPREHENSIVE HISTORY PAGE 3
WC 1008

Patient Name _____
DOB

Past Surgical History (Throughout your entire life)

Type of Surgery	Date	Comments

Personal and Family Medical History — Place a check mark in the box if applicable for yourself or family member

Disease/ Medical Condition	Yourself	Family member	PLEASE EXPLAIN OR GIVE DETAILS HERE
Blood Clot/DVT			
Anemia			
Asthma			
Autoimmune Disease			
Bruising/Bleeding Disorde			
Coronary Artery Disease			
Cardiovascular Disease			
Anxiety			
Recurrent Urinary Tract Infections			
Elevated Cholesterol			
Diabetes/Gestational Diabetes			
Endometriosis			
Fibroids			
Gallbladder Disease			
Herpes Simplex Virus			
Hypertenstion			
Infertility			
Blood transfusions			
Osteoporosis			
Ovarian Cyst			
Breast disease			
Breast Cancer			
Ovarian Cancer			
Cervical Cancer			
Uterine Cancer			
Colon Cancer			
Thyroid Disease			
Stroke			
Polycysitic Ovarian Syndrome			
HIV/AIDS			
Other, explain			

Social History

Occupation _____ Marital Status Single/ Married/ Divorced/Separated

RACE (Medically Required CIRCLE ONE) AfricanAmerican Asian American Indian Caucasian Hispanic Indian Jewish/Eastern European Middle Eastern Pakistani Other _____

Do you currently smoke? YES/ NO Amount? _____ Did you smoke in the past? YES/ NO

When did you quit? _____ Ever tried to quit? YES / NO

Passive smoke exposure at home or work? YES / NO

Do you drink alcohol? YES / NO Type of alcohol _____ How often _____

Do you feel you drink too much alcohol? YES / NO

Do you eat/drink caffeine? YES/NO Type _____ Frequency _____

In a medical emergency, would you accept blood products? YES / NO

Have you ever sought treatment for alcohol or drug use? YES / NO / N/A

Do you currently use recreation drugs? YES/ NO What substances do you use? _____

Have you used recreational drugs in the past? YES / NO

Have you ever been abused ? YES / NO

Are you being abused at this time? YES / NO Are you concerned about your safety? YES/ NO

What is your sexual preference? Heterosexual/ Bisexual/ Lesbian