Female History Form

Name County Health Department

Client Name_____ **Age**___ **DOB**___/____/_____ **ID#**_____

Reason for today's visit: _____ **Are you allergic to any medications, foods, latex, metals, or other**? ___No ___Yes

Please list_____

General Health

Have you ever had or do you have:

No	Yes		No	Yes	
□	□	Diabetes / Thyroid Problems	□	□	Problems with your kidneys or bladder
□	□	Seizures	□	□	Cancer
□	□	Heart attacks or strokes	□	□	High blood pressure
□	□	Breast surgery or problems	□	□	Hepatitis (skin turned yellow) or gallbladder problems
□	□	Depression	□	□	Pelvic infection treated in the hospital
□	□	Migraines with aura	□	□	Uterine fibroids or ovarian cysts
□	□	Blood Clot in your blood vessels like leg or lung	□	□	Problems with vision or hearing
□	□	Blood transfusions	□	□	Eczema or skin problems
□	□	Shortness of breath	□	□	Problems with muscles / bones
□	□	Anemia	□	□	High Cholesterol

□ □ Have you ever had any other medical conditions, any surgery or been hospitalized? If yes explain_____

_____

How many times a week do you exercise? _____ Per day, how many fruits___ vegetables____ dairy_____ grains____ meat _____ do you eat?

Do you chew / smoke tobacco? ___No ___Yes If yes how many cigarettes a day? ____ How long have you chewed / smoked? _____

How many alcoholic beverages do you drink per day___, week___, month___? Are you worried about your alcohol use? ___No ___Yes

Do you currently use street drugs? ___No ___Yes If yes how many times a week?____

Do you or have you used injectable drugs? ___No ___Yes If yes, how often?____ Last time used? _____

List the medications you are taking, how often and how much. Include prescriptions, over the counter (Ibuprofen, Tylenol), herbs, & vitamins:

_____

The date of your last mammogram_____ and results? _____ If age 50 or older, have you had colon cancer screening? ___No ___Yes

Immunizations

Please give the date of your last immunizations. (A tetanus booster dose is recommended every 10 years.)

_____MMR (1 or 2 doses) _____Td/Tdap _____Hepatitis B, series _____HPV vaccination Other, list_____

Family History Are you adopted? ___No ____Yes (If yes and you do not know your family history, you are done with this section)

Have any of your blood relatives had the following conditions? Please say who they are. (Include your mother, father, brothers, and sisters)

___Diabetes_____ ___High cholesterol / triglycerides_____ ___Sickle Cell Anemia_____

___Cancer _____(type) _____ ___High blood pressure_____ ___Stroke_____

___Phlebitis or clots in the veins _____at what age_____ ___Heart disease or heart attack _____ at what age_____

If born before 1971, did your mother receive a hormone called Diethylstilbestrol (DES) while pregnant with you? ___No ___Do not know ___Yes

Psychosocial: Do you have any problems at home, work, or school that are bothering you? ____No ___Yes If yes, please explain_____

_____

Menstrual

How old were you when your periods began? _____ Date of last period (1st day) _____ Is your period overdue? ___No ___Yes

How many days does your period last? _____ How many days from the start of one period until the start of the next period? ___

Do you bleed between periods? ___No ___Yes How many pads/tampons do you use per day? _____

Do you have pain with your periods? ___No ___Yes If yes, what to you do to relieve this pain? _____

Do you have menstrual tension, weight gain, backache, or mood changes before your period? ___No ___Yes

Pap Smears Is this your first Pap Smear? ___No ___Yes (If this is your first pap smear, skip this section)

When was your last Pap Smear? _____ What were the results? ___Normal ___Abnormal ___Do not know

If you have ever had an abnormal Pap Smear when and what treatment: _____

Pregnancy

Have you ever been pregnant? ___No (If no, you are done with this section) ___Yes Age at first pregnancy____

# of pregnancies____ # of deliveries____ Date of your last delivery_____ # of living children_____

# of miscarriages____ # of abortions_____ # of ectopic____

Describe any complications you had during pregnancy (example: high blood pressure; depression; high blood sugars): _____

Are you currently breastfeeding? ___No ___Yes Do you have plans for more children? ___No ___Yes ___Undecided

Sexual

How old were you when you first had intercourse? _____ When you were young did someone ever put something in your vagina? ___No ___Yes

Are you experiencing any pain, discomfort or bleeding with or after intercourse? ___No ___Yes If yes, describe_____

Have you recently been treated for a vaginal infection? ___No ___Yes If yes, describe_____

Do you have any symptoms of vaginal infection, such as itching, burning, odor, or unusual discharge? ___No ___Yes (list) _____

Have you been treated for a sexually transmitted disease in the last year? ___No ___Yes What_____

Have you been treated for a pelvic inflammatory infection in the last year? ___No ___Yes If yes, when? _____

Have you had a new sexual partner or more than one sexual partner in the last year? ___No ___Yes How many partners in your lifetime? _____

Were/Are your sexual partners: □ men □ women □ both □ IV drug users □ partner with multiple partners or at risk for HIV/STD

What types of sex have you had? □ Oral □ Anal □ Vaginal □ None

Have your ever been physically abused (hit, kicked, slapped)? ___No ___Yes

Have you ever been emotionally abused (threatened, made to feel worthless)? ___No ___Yes

Has anyone, including partner or family member ever forced you to have sex? ___No ___Yes

What do you do to protect yourself from being infected with HIV/STD? _____

Contraceptives

Check all of the birth control methods you have used:

___Abstinence (not having sex)	___Pill	___Sterilization	___Foam, suppository, gel, film
___Withdrawal	___Condoms	___Diaphragm	___Depo Provera
___Norplant / Implanon	___IUD	___Sponge	___Birth Control Patch
___Vaginal ring	___Natural Family Planning		Other_____

What is the most recent birth control method you have used? _____

Are you using this method now? ___No If no, when did you stop using it? _____ ___Yes If yes, how long have you been using it? _____

Have you had problems with any birth control methods? ___No ___Yes If yes, describe_____

_____ _____

Client signature and date **Client signature and date updated**

For office use only

Summary of Findings / Recommendations / Referrals: _____

_____

_____

_____

Counseling

Topic	Addressed*	NA	Addressed	NA
Health Promotion				
Tobacco cessation				
Drug/Alcohol Use				
STD/HIV risk reduction				
Overview/Review of Method (s)				
Adolescents Only				
Abstinence				
Resisting Sexual Coercion				
Family Participation				
Report of Abuse or Neglect				

***√ individual boxes when topic Addressed or √ NA when Not Applicable**

Scheduled for exam on_____ Method given_____

Reviewed by: _____ Date_____

Updated by: _____ Date_____

Revised: September 2008