Women's Specialty & Fertility Center

Health History

Name: _____DOB: _____ Age: _____ Date: _____

Primary Care Physician: _____ OB/GYN: _____ Occupation: _____

First Day of Last Menstrual Period: _____ Race/Ethnicity: _____ Spouse Race/Ethnicity: _____

Allergies to medication and reaction: _____ Allergic to peanuts: ☐ Yes ☐ No Allergic to iodine: ☐ Yes ☐ No

Preferred Local Pharmacy: _____ Mail Order Pharmacy: _____

Current prescription and over the counter medications: _____

_____

MEDICAL HISTORY: *Check box (x) if you have, or ever had any of the following:*					
Abnormal Pap		German Measles		Pelvic Infections	
Anemia		Heart Disease		Pelvic Inflammatory Disease	
Asthma		Hepatitis		Pneumonia	
Blood Transfusions		History STD		Rheumatic Fever	
Breast Disease		Hypercholesterolemia		Stomach Problems	
Cancer		Hypertension		Syphilis	
Colon Disease		Immune Disorders		Thyroid Disease	
DES Exposure		IUD		Tuberculosis	
Diabetes		Kidney Disease		Uterine Abnormalities	
Endometriosis		Liver Disease		Valley Fever	
Epilepsy		Lung Disease		Other	
Fibroids		Menopause			

SURGICAL HISTORY: *Check box (x) if you have, or ever had any of the following:*					
Abdomen Surgery		Colon Surgery		Hysteroscopy	
Appendectomy		Cosmetic Surgery		Laparoscopy	
Brain Surgery		D&C		Ovary Removal	
Breast Surgery		Ectopic Surgery		Reanastomosis Tubal	
C-section		Endometrial Ablation		Spine Surgery	
Cardiac Surgery		Hernia Repair		Tubal Ligation	
Cholecystectomy		Hysterectomy		Tubal Surgery	

Please list type of surgery and date performed:

_____

_____

Patient Name: _____ DOB: _____

FAMILY HISTORY

	No Known Problems	Add Problem	Bleeding Problem	Cancer	Genetic Problem
Mother					
Father					
Sister					
Brother					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					
Father of baby					

SOCIAL

Do you drink alcohol: □ Yes □ No If yes, how often: _____

Birth control method: _____

History of recreational drug use: □ Yes □ No If yes, what type and when last used: _____

Current smoker □ Yes □ No Smokeless tobacco: □ Yes □ No

Sexual Preference: □ Prefers Male □ Prefers Female Sexual Identification: □ Identifies as Female □ Identifies as Male □ Identifies as Neither

GYNECOLOGIC HISTORY

How old were you when you had your first period? _____
Menstrual cycle length: (circle one) < 28 days every 28 days > 28 days
Irregular periods: □ Yes □ No
How many days does your cycle last: (circle one) < 3 days 3-7 days >7 days
Heavy periods: □ Yes □ No
Number of tampons/pads used per day: _____
Non-menstrual bleeding: □ Yes □ No
Painful menstrual cramps: □ Yes □ No
Painful intercourse: □ Yes □ No
Pelvic pain: □ Yes □ No
Pelvic pain chronicity: (circle one) new recurrent chronic
When was your last pap smear? _____
When was your last mammogram? _____
Discharge from breasts: □ Yes □ No
Breast mass: □ Yes □ No
Recent hair changes: □ Yes □ No
Recent voice changes: □ Yes □ No