FEMALE PATIENT HISTORY SHEET

PATHWAY Health Clinic

LEGAL NAME_____ DATE _____/_____/_____

BIRTH DATE____/_____/_____ CLIENT #_____

*MAJOR MEDICAL CARE IN THE PAST YEAR?_____ *WHO IS YOUR PRIVATE DOCTOR?_____

ARE YOU PREGNANT?
Yes or No

***CHIEF COMPLAINT:**_____

***MEDICATION ALLERGIES:** _____

_____

***CURRENT MEDICATIONS:**_____

_____

_____

***TRAVEL**

In the last 30 days, have you traveled outside of the U.S.? YES___ NO ____

***VACCINE HISTORY AND DATES**

YES	NO	
		Tetanus
		Hepatitis B
		Hepatitis A
		Gardasil
		Rubella (German Measles)

***MEDICAL HISTORY-FAMILY MEMBERS**

YES	NO	
		Diabetes
		High Blood Pressure
		Epilepsy
		Migraine Headaches
		Cancer
		Heart Attack before age 50
		Genetic problems
		Maternal exposure to DES
		High cholesterol
		Sickle cell anemia

***MENSTRUAL HISTORY**

First date of last period_____

Age periods began_____

How many days between periods____

How many days of bleeding_____

*In the past 3 months, have you had any of the following problems?

YES	NO	
		Menstrual discomfort/cramps
		Pain or burning with urination
		Unusual vaginal discharge
		Vaginal itching, burning, sores
		Pain/bleeding with intercourse
		Missed periods

LAST PAP SMEAR_____

Results_____

IS THIS YOUR FIRST PELVIC EXAM? YES_____ NO_____

***PREGNANCY HISTORY**

No. of pregnancies_____

No. of live births_____

No. of miscarriages_____

No. of stillbirths_____

No. of induced abortions_____

No. of living children_____

Your age with first pregnancy_____

Last delivery date_____

_____

Types of Delivery:

Vaginal_____C-Section_____

Complications with any pregnancy? YES_____NO_____

i.e., Toxemia, genetic problems, diabetes YES_____NO_____

If yes, explain_____

_____

Have you ever had a tubal pregnancy? YES_____NO_____

Have you ever had any premature deliveries? YES_____NO_____

***CONTRACEPTIVE HISTORY**

Current method of birth control?

_____

Methods of birth control used:

	Pill
	IUD
	Diaphragm
	Vasectomy
	Sterilization/Tubal
	Foam/cr. suppos.
	Nat. Family Plng.
	Condoms
	Sponge
	Withdrawal
	Implant
	Patch
	NuvaRing
	Depo Shot

Problems with any of these methods:

_____

What method do you want to use now?

_____

***BIRTH CONTROL PILL USERS**

Since your last visit, have you had problems with any of the following:

YES	NO	
		Chest Pain
		Headaches (severe)
		Blurred vision
		Leg pains
		Dizziness
		Shortness of breath
		Depression

***SEXUAL HISTORY**

Age of first intercourse?_____

Are you currently sexually active?
YES___ NO___

When was your last sexual encounter?
_____

Do you think you might be pregnant now?
YES____ NO____

Have you had sex without using any birth control since your last period?
YES____ NO____

Have you had more than one sex partner during your life? YES____ NO____

Approximately how many?_____

In the past 3 months, how many people have you had sex with? _____

In the past 12 months, how many people have you had sex with? _____

Do you have sex with:
Men Women Both

Do you have vaginal sex?
Yes No

Do you have anal sex?
Yes No

Do you have oral sex?
Give Receive

ASSURANCE OF CONFIDENTIALITY:

This medical record is confidential and will not be released to anyone without your consent except as may be required by law.

LEGAL NAME_____ CLIENT #_____

BIRTH DATE_____/_____/_____

PATHWAY Health Clinic

***RISK EXPOSURE INFORMATION**

YES	NO	
		Homo/Bisexual
		IV Drug User
		Hemophilia
		Prostitute
		Trade Sex for Drugs
		Sex Partner of Homo/Bisexual
		Sex partner of IV Drug User
		Sex Partner with AIDS/HIV+
		Has anyone requested sexting or nude pictures of you?
		Have you had sex while drinking alcohol?
		Had sex with someone you don't know?
		Had sex with someone you met over the internet?

***PAST STD HISTORY**

YES	NO	
		Have you been tested/treated for an STD in the past 12 months? Gonorrhea/Chlamydia/Trich/Warts Herpes or Syphilis
		Has your partner(s) been tested/treated for any STD in the past 12 months? Gonorrhea/Chlamydia/Trich/Warts Herpes or Syphilis
		Have you ever had or been told you had hepatitis?
		Have you taken any antibiotics for infection recently?

***PROTECTION FOR STD's**

How do you protect yourself/partner from STD's and HIV/AIDS?

_____

How often do you use condoms?

Always Sometimes Never

***SIGNS/SYMPTOMS**

YES	NO	**Today or in the Last 3 Days**
		Unusual discharge from vagina or penis?
		Itching or burning with urination?
		Unusual vaginal bleeding or bleeding after sex?
		Bumps or sores on/around your penis/vagina?
		Itching or burning in your genital area?
		Pain with intercourse?

***HOSPITAL/SURGICAL HISTORY**

OB/GYN Breast Surgery_____

***OTHER SURGERY OR MAJOR HOSPITALIZATIONS:**_____

***REPRODUCTIVE LIFE PLAN**

Do you plan to have children (more) ? _____

If you become pregnant, you plan to: _____

***HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?**

YES	NO	
		Surgeries/Hospitalizations
		Anemia/Sickle Cell Anemia/Immune Disorders/Lupus
		Asthma/Respiratory Problems
		Bladder Infections/Problems/Kidney Infections
		Blood clots in veins/varicose veins
		Blood transfusion prior to 1993
		Breast disease/Lump/Nipple discharge
		Cancer
		Depression/Emotional Problems
		Diabetes
		Eating disorders: obesity, anorexia, bullimia
		Epilepsy
		Frequent or severe headaches/migraines
		Gall bladder problems/Infections
		Genetic problems
		Heart Attack before age 50
		Heart problems/murmurs/High blood Pressure
		Hepatitis/Liver Problems
		High cholesterol
		Intestinal problems/Stomach
		Maternal exposure to DES
		Mononucleosis
		Thyroid problems
		Substance abuse
		Uterine growths/Fibroids/Ovarian cysts
		Infection of uterus, tubes, ovaries
		Abnormal PAP smear When:
		VD/Gonorrhea/Syphillis/Herpes
		Warts/Chlamydia
		Vision problems
		Hearing problems

YES	NO	
		Do you smoke cigarettes, use street drugs, tobacco or alcohol? If yes, specify amount. _____
		Sexual Abuse (Actual or potential) You /children
		Domestic Violence (Actual or potential) You/Children
		Are you afraid of your partner or any family member?
		Have you been forced into sex or sexual activities?
		Have you been hit, slapped, punched, shoved, kicked, etc?

Signature:_____

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE

Staff reviewed _____[initials]

Clinician reviewed _____[initials]