The Northwestern Specialists For Women

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WOMEN'S MEDICAL HISTORY

Name:_____ **Today's Date** _____ Occupation: _____

Age: _____ Referred by: _____

REASON FOR SEEING DOCTOR TODAY

_____

_____

OBSTETRIC HISTORY

Total Number of Pregnancies _____
History No. of Term Births _____
No. of Pre-Term Births _____
No. of Miscarriages _____
No. of Abortions _____
No. of Ectopic Pregnancies _____
No. of Living Children _____

Complications of Pregnancy:
- □ Diabetes
- □ High blood pressure
- □ C-section
- □ Preeclampsia
- □ Other:_____

GYNECOLOGIC INFORMATION

Contraceptive History: check all birth control methods you have used

□ Natural Family Planning or Rhythm Method □ Spermicide/Foam □ Condoms □ Diaphragm □ Norplant
□ Depo-Provera Injections □ IUD □ Tubal Ligation □ Vasectomy
□ Oral Contraceptives/Type _____
Any complications _____

Sexual History:

Are you currently sexually active? □ Yes □ No
If no, have you ever been? □ Yes □ No
If yes, number of partners: last year ____; ever ____
Sexual Orientation Heterosexual Lesbian Bisexual Binary Trans-sexual Asexual

Gynecologic History

Age of first menstruation ____ Interval Between Periods _____ Days of Bleeding ____
Date of last normal menstrual period _____ Usual number of pads/tampons on heaviest day ____
Do you have pain/cramps with your period? □ None □ Mild □ Moderate □ Severe
If menopause, year began? _____ Any bleeding since? □ Yes □ No
Last mammogram _____ Last bone density test _____ Colonoscopy _____

Have you ever had an abnormal PAP test?	□ Yes □ No
Have you ever had a colposcopy or biopsy?	□ Yes □ No
Do you bleed between your periods?	□ Yes □ No
Were you exposed to diethylstilbestrol (DES) before birth?	□ Yes □ No
Do you experience pain with intercourse?	□ Yes □ No
Do you experience bleeding after intercourse?	□ Yes □ No
Do you experience pain between periods?	□ Yes □ No
Are you currently experiencing vaginal discharge?	□ Yes □ No
Are you currently experiencing vaginal itching or discomfort?	□ Yes □ No
Have you experienced prolapse of bladder uterus or bowel?	□ Yes □ No
Have you experienced leakage from bladder or bowel?	□ Yes □ No

Do you have or have ever had

Fibroids/myomas	□ Yes □ No	Gonorrhea	□ Yes □ No	Pelvic Inflammatory Disease	□ Yes □ No
Endometriosis	□ Yes □ No	Chlamydia	□ Yes □ No	Bacterial Vaginosis	□ Yes □ No
Infertility	□ Yes □ No	Syphilis	□ Yes □ No	Yeast	□ Yes □ No
		Genital warts/HPV	□ Yes □ No	Trichomonas	□ Yes □ No
		Herpes	□ Yes □ No		
		HIV/AIDS	□ Yes □ No		

MEDICATIONS and ALLERGIES

Are you on any medications (including contraception)?

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

Do you take any:

Herbal products	□ Yes □ No
Vitamins	□ Yes □ No
Minerals	□ Yes □ No

Do you have any allergies to any medications □ Yes □ No

Penicillin? □ Yes □ No Reaction _____ Sulfa Drugs? □ Yes □ No Reaction _____
Codeine? □ Yes □ No Reaction _____Other _____Reaction_____

Women's Medical History—page 2 **Name:** _____

MEDICAL HISTORY (check all those that apply)

☐ Ovarian Cancer ☐ High Blood Pressure ☐ Diabetes ☐ Asthma ☐ Lung Disease ☐ Sickle Cell
☐ Uterine Cancer ☐ Thyroid Disease ☐ Lupus ☐ UTIs ☐ Kidney Disease ☐ Kidney stones
☐ Cervical Cancer ☐ Hepatitis ☐ Gallbladder ☐ Blood Clots ☐ Irritable Bowel/Colitis ☐ Anemia
☐ Breast Cancer ☐ Skin Cancer ☐ Blood disorder ☐ Depression ☐ Anxiety ☐ GI Reflux/Ulcers
☐ Other _____

PAST SURGICAL HISTORY (check all those that apply)

☐ Hysterectomy ☐ Gallbladder ☐ Thyroid ☐ Appendix ☐ Hernia ☐ Tonsils
☐ Wisdom Teeth ☐ Spine/Joint ☐ Heart ☐ Other _____

VACCINATION HISTORY (check all those that apply)

☐ Hepatitis B ☐ Pneumonia ☐ Chicken Pox (or history of) ☐ TDaP ☐ HPV/Gardasil ☐ Measles/Mumps/Rubella ☐ Influenza

SOCIAL HISTORY

Highest level of education: _____ If married or in domestic partnership, how long? _____ years. Any previous marriages and how many _____
Who currently lives in household? _____

Do you regularly exercise? ☐ Yes ☐ No
Do you regularly use sun block ☐ Yes ☐ No
Do you have regular dental exams ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No
How much _____
Total years_____
Quit date _____
Have you ever used illicit drugs ☐ Yes ☐ No
Have you ever been physically abused? ☐ Yes ☐ No
If yes, in the past 12 months? ☐ Yes ☐ No

Do you regularly wear a seat belt ☐ Yes ☐ No
Do you have regular eye exams ☐ Yes ☐ No
Do you regularly examine your breasts ☐ Yes ☐ No
Do you drink alcohol ☐ Yes ☐ No
How much? ☐ 1-7 /week ☐ >8 /week
More than 5 drinks/sitting ☐ Yes ☐ No
Has anyone been concerned? ☐ Yes ☐ No
Are there firearms in your home? ☐ Yes ☐ No
Have you ever been sexually abused? ☐ Yes ☐ No
If yes, in the past 12 months? ☐ Yes ☐ No

FAMILY HISTORY

☐ Heart Disease ☐ Thyroid ☐ Uterine Cancer ☐ Breast Cancer ☐ Osteoporosis ☐ High Blood Pressure ☐ Diabetes
☐ Ovarian Cancer ☐ Colon Cancer ☐ Endometriosis ☐ Leukemia/lymphoma ☐ Skin cancer ☐ Other _____

Are your parents still living? _____ Are you Adopted? _____

REVIEW OF SYMPTOMS (check if you currently have any of the following symptoms)

General
Weight gain/loss ☐ Yes ☐ No
Loss of appetite ☐ Yes ☐ No
Fatigue/Weakness ☐ Yes ☐ No

Breast
Lumps ☐ Yes ☐ No
Discharge ☐ Yes ☐ No

Eyes
Wear contacts ☐ Yes ☐ No
Blurry vision ☐ Yes ☐ No

Ear/Nose/Throat
Trouble hearing ☐ Yes ☐ No
Nosebleeds ☐ Yes ☐ No
Mouth sores ☐ Yes ☐ No
Congestion ☐ Yes ☐ No

Skin
Changing Moles ☐ Yes ☐ No
Rash ☐ Yes ☐ No

Respiratory
Persistent Cough ☐ Yes ☐ No
Shortness of Breath ☐ Yes ☐ No

Heart
Palpitations ☐ Yes ☐ No
Blood Clots ☐ Yes ☐ No
Murmur ☐ Yes ☐ No

Gastrointestinal
Bloating ☐ Yes ☐ No
Constipation ☐ Yes ☐ No
Diarrhea ☐ Yes ☐ No
Blood in stool ☐ Yes ☐ No
Nausea/Vomit ☐ Yes ☐ No
Heartburn ☐ Yes ☐ No

Urinary
Leaking bladder ☐ Yes ☐ No
Blood in urine ☐ Yes ☐ No
>2 nightly ☐ Yes ☐ No
Frequent urination ☐ Yes ☐ No

Muscles
Joint pain ☐ Yes ☐ No
Chronic Back pain ☐ Yes ☐ No

Endocrine
Abnormal hair growth ☐ Yes ☐ No
Heat intolerance ☐ Yes ☐ No
Cold intolerance ☐ Yes ☐ No
Hot flashes ☐ Yes ☐ No
Night sweats ☐ Yes ☐ No

Mental Health
Marital problems ☐ Yes ☐ No
Persistent anxiety ☐ Yes ☐ No
Trouble sleeping ☐ Yes ☐ No
Depressed ☐ Yes ☐ No
Suicidal thoughts ☐ Yes ☐ No

Neuro
Chronic headaches ☐ Yes ☐ No
Seizures ☐ Yes ☐ No