FAMILY CARE HEALTH CENTERS
FEMALE HISTORY

NAME **AGE** **DOB** **ID#** **Today's Date**

Please list allergies(medications, foods, latex, metals, other):

Past Health History

Current medications (prescription, over the counter, herbal) _____

_____

_____

Major illness/ Injuries/Disability: _____

_____

_____

_____

Hospitalizations/Surgery_____

_____

_____

_____

Have you ever had a blood transfusion ___**Yes** ___**No**
Have your had other blood exposure ___**Yes** ___**No**
Immunizations: __MMR (1 or 2 doses) __Td/TDaP __Hepatitis B (1 2 3 doses) __HPV vaccination (1 2 3 doses) __Other

Health Habits:
How can we help you with questions about your diet/nutrition?_____
Do you have concerns about your weight? ___Yes ___No Do you take folic acid daily? ___Yes ___No Do you use seat belts? ___Yes ___No
How many times a week do you exercise? _____ Do you have concerns about your sleeping habits? ___Yes ___No

Personal Risk:
Do you use tobacco ? ___Yes ___No Type _____ amount per day_____ Do you use cigarette substitutes? ___Yes ___No Type? _____
Do you drink alcohol? ___Yes ___No How much, how often? _____ Do you now or have you ever used IV Drugs? ___Yes ___No
Do you now or have you used street drugs or prescriptions for recreational use? ___Yes ___No Type_____
Have you ever sought treatment for substance abuse? ___Yes ___No

Family Health History:
Are you adopted? ___Yes **(If yes and you do not know your family history, you may skip this section)** ___No (please continue 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 you were born before 1971, did your mother receive a hormone called Diethylstilbestrol (DES) while pregnant with you? ___ Do not know/not sure ___Yes ___No

Sexual History:
Have you ever had sex? ___Yes ___No
(If no, you may skip this section)
What types of sex have you had? ___Oral ___Anal ___Vaginal
How old were you when you first had intercourse? _____
Are you experiencing any pain, discomfort or bleeding with or after intercourse? ___Yes ___No
Have you had a new sexual partner or more than one sexual partner in the last year? ___Yes ___No
How many sexual 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 ___recently treated for STD
Please circle any of the following that you have been treated for:
Chlamydia Gonorrhea Syphilis Hepatitis B
Treatment date(s) _____
Was your partner also treated? ___Yes ___No

Pregnancy History:
Do you plan to have children? ___Yes ___No
If yes, when? _____
Would you like information that could help you to have a healthy pregnancy when the time is right for you? ___Yes ___No
If you do not plan to have children now or ever, how do you plan to prevent pregnancy? _____
Have you ever been pregnant? ___Yes ___No (**If no, skip this section**)
Age at first pregnancy: _____
Have you been pregnant within the past year? ___Yes ___No
Number of times pregnant: _____
Number of live births: _____
Number of living children: _____ Ages: _____
Number of C-sections: _____
Number of miscarriages: _____
Number of abortions: _____
Number of ectopic/tubal pregnancies: _____
Describe any problems you had during pregnancy (high blood pressure; depression; high blood sugars)_____
Are you breastfeeding now? ___Yes ___No
Do you think you may be pregnant now? ___Yes ___No

Menstrual:
How old were you when your periods began? _____
When did your last period start? (date) _____
Was this period normal? ___Yes ___No
Is your period late? ___Yes ___No
How many days does your period last? ____ **(≥8 days)**
How many days from the start of one period until the start of your next period? ____ **(≤20 or ≥36 days)**
How many pads/tampons per day do you use? _____
Do you bleed between periods? ___Yes ___No
Have you noticed a change in your periods? ___Yes ___No
Do you have pain with periods or in between? ___Yes ___No
Do you have irritability, weight gain, backache, or mood changes before or during your period? ___Yes ___No
Do you have clots with your periods ___**Yes** ___**No**

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 birth control now? ___Yes ___No
If yes, how long have you been using it? _____
If no, when did you stop using it? Why did you stop using it?
_____
Have you had problems with any birth control methods? ___Yes ___No
If yes, describe_____
Do you want a birth control method today ___Yes ___No
What method do you think you would like to have? _____
Does your partner ever sabotage your birth control? ___Yes ___No
Does your partner pressure you to get pregnant if you don't want to? ___Yes ___No

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SOCIAL INFORMATION:

Have you ever been hit, slapped, kicked or verbally abused? ___Yes ___No

Have you ever been forced to have sex or perform sexual acts when you didn't want to? ___Yes ___No

Have you ever been sexually molested? ___Yes ___No

Do you have someone to talk to when you are sad or feel bad? ___Yes ___No

Are you currently in an abusive relationship? ___Yes ___No

Are you afraid of your partner or anyone else? ___ Yes ___No

(parent, relative, neighbor, etc)?

Are you safe at home? ___Yes ___No

PAP HISTORY:

Have you ever had a PAP smear? ___Yes ___No

(if no, you may skip this section)

When was your last Pap smear? _____

Where was your last pap smear done?_____

Have you **ever** had an abnormal Pap smear? ___Yes ___No

If yes, when? _____ What was the treatment?_____

REVIEW OF SYSTEMS

No = no problems with this now Yes = having problems now Past = have had this problem in the past

NO	YES	PAST	GENERAL
			rapid weight gain or weight loss
			recent weight loss (unintended)
			frequent cold, flu, etc.
			chronic fatigue >6 months
			cancer: _____
			genetic condition: _____
			HIV/AIDS
NO	**YES**	**PAST**	**CARDIOVASCULAR**
			heart disease/ heart murmur
			high blood cholesterol
			varicose veins
			high blood pressure
			blood clot in lungs or veins
			stroke
NO	**YES**	**PAST**	**NEUROLOGIC**
			migraines (diagnosed)
			sensory difficulties (numbness, smell, taste)
			seizures/epilepsy/dizziness/fainting
NO	**YES**	**PAST**	**GASTROINTESTINAL**
			stomach/bowel problems (constipation, diarrhea, blood in stool)
			liver disease/jaundice/mono
			hepatitis
			gall bladder disease
NO	**YES**	**PAST**	**SKIN**
			acne
			chronic rash or itching
			breast: discharge, lump, surgery
			other skin problem: _____
NO	**YES**	**PAST**	**MUSCULOSKELETAL**
			fractures/broken bones
NO	**YES**	**PAST**	**AUTOIMMUNE**
			Lupus
			rheumatoid arthritis
			fibromyalgia

NO	YES	PAST	RESPIRATORY
			asthma
			tuberculosis (TB)
			chronic cough
NO	**YES**	**PAST**	**GENITOURINARY**
			frequent bladder infections
			bladder, urinary, or kidney problems
			abnormality of the uterus/ovaries: _____
			pelvic pain
			pelvic infection/PID
			vaginal infection/discharge/odor
			sores, bumps, rash
			endometriosis
			Other:_____
NO	**YES**	**PAST**	**HEMATOLOGIC**
			anemia
			blood clotting disorder
			sickle cell disease
NO	**YES**	**PAST**	**ENDOCRINE**
			diabetes/diabetes in pregnancy
			thyroid problems
NO	**YES**	**PAST**	**EYES**
			eye problems (NOT GLASSES OR CONTACTS)
NO	**YES**	**PAST**	**EARS, NOSE, THROAT, MOUTH**
			frequent nosebleeds
			hearing problems
			teeth/gum problems
			frequent sore throat
NO	**YES**	**PAST**	**PSYCHOLOGIC**
			anxiety
			depression
			severe mood swings
			thoughts of suicide
			any traumatic, painful or emotional event

Is there anything else we should know about you? _____

I have received information on the benefits and risks, effectiveness, potential side effects, complications, discontinuation issues and danger signs of the contraceptive method chose. I have been counseled, provided with appropriate informational materials and I understand the content.

Client Signature _____ Date _____

Reviewed by Health Care Provider _____ Date _____

Form Reviewed/Revised: April 2012