Laramie Physicians for Women and Children
Women's Health History

Today's Date: __________

Name:________________________________ Date of Birth:______________ Age:_______

Emergency Contact and Phone Number: _________________________ (   ) ______-____________

Do you have any personal or religious objections to treatment or vaccinations? Yes No

If yes, please explain: ____

Current Prescription Medications **PREFERRED PHARMACY:**________________________

Name Dose Frequency

Current "Over-the-counter" Medications (include Vitamins and Supplements)

Name Dose Frequency

Allergies (Food or Medication)

Drug Name: Reaction:

Latex: Y N Iodine: Y N Food:

Other:

Menstrual History

What was the first day of your last period?

Describe the amount of menstrual flow: Light Moderate Heavy

How many days do you flow? How often do your periods start? (i.e. every 28 days)

What age did you start your periods? What age did your periods stop?

Do you have painful periods? Yes No

Do you have history of infertility? Yes No

Do you have endometriosis? Yes No

Do you bleed between periods? Yes No

Do you flow twice as much as you did 10 years ago? Yes No

Do you have pain with intercourse?

Do you have bleeding during or after intercourse?

Child Bearing History

How many times have you been pregnant?

How many full term deliveries(37 weeks or greater)? Preterm Deliveries(<37 weeks)? Multiple Births(i.e. twins)?

How many live births? # Vaginal? # Cesarean?

How many miscarriages? Abortions? Ectopic?

How many living children? Adopted?

Deceased children? # Stillborn?

GYN History

When was your last pap smear? Was it normal? Yes No

Have you ever had an abnormal pap smear? Yes No

Have you ever had a procedure for an abnormal pap smear? Yes No

If yes, which procedure? When?

How many sexual partners have you had in your lifetime? Have your sexual partners been: Men Women Both

Have you ever tested positive for any sexually transmitted diseases? Yes No

If yes, which STD(s)? Treatment? When?

Please circle the method(s) of contraception you're currently using:

Pill Condoms Rhythm Hysterectomy Tubal Vasectomy Implanon IUD Depo Withdrawal Nuva Ring None

Are you currently taking female hormones? Yes No Which ones?

Do you have symptoms of menopause?

Painful intercourse Irritability Hot flashes Mood changes Vaginal dryness Insomnia Night sweats

Do you examine your breasts monthly? Yes No

Continue →

Have you noticed a change in your breast(s) or nipple(s)? Yes No

Do you have breast implants? Yes No When?
Have you had a mammogram? Yes No When?
Have you had an abnormal mammogram? Yes No When?
Have you ever had a breast biopsy? Yes No When?
Do you lose urine when you cough or sneeze? Yes No If yes, do you have to wear a pad? Yes No

Medical History

Hospitalizations:
Date: Reason:

Chronic Illness:
Serious Injuries/Accidents:
Date: Type:

Infections:
Type: When: Treatment:

Surgical History

Date: Surgery: Surgeon: Facility: Reason: Complications:

Social History

Sexually Active? Yes No
Marital Status: Married Single Widowed Divorced Separated
Occupation: Hours/week:
Stress Level: Low Moderate High
Diet: Balanced Low Sugar Low Salt No particular Other:
Exercise: Minimal Regular Very active
Seat Belt: Always Never Most of the time
Smoking: Yes No How often: How long:
Alcohol: Yes No How often: How long:
Illicit Drugs: Yes No How often: How long:
Domestic Abuse: Yes No How often: How long:

Family History – Circle if anyone in your family (parents, siblings, grandparents, etc.) had/has any of the following:

Diabetes: Yes No Who? Mother/Fathers family? Alive? Y N
Muscle/Joint Conditions: Yes No Who? Mother/Fathers family? Alive? Y N
Nervous/Mental: Yes No Who? Mother/Fathers family? Alive? Y N
High blood pressure: Yes No Who? Mother/Fathers family? Alive? Y N
Stroke: Yes No Who? Mother/Fathers family? Alive? Y N
Heart disease: Yes No Who? Mother/Fathers family? Alive? Y N
Lung disease: Yes No Who? Mother/Fathers family? Alive? Y N
Cancer: Type: Yes No Who? Mother/Fathers family? Alive? Y N
Other: Yes No Who? Mother/Fathers family? Alive? Y N

Clinical Dates

Have you ever had your wellness labs drawn? Yes No When?
Have you ever had a bone density test? Yes No When?
Have you ever had a colonoscopy? Yes No When?
Have you had a thyroid test within the past year? Yes No When?
Have you had a TDAP immunization? Yes No When?
Have you had a Hepatitis B Immunization? Yes No When?
Have you had a Flu Vaccine? Yes No When?

Additional Comments:

CNA initials / date: