

# Women's Health History

Name (please print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

*For WHA Use Only*  
Affix Centricity Label Here

## Menstrual History

How old were you when you first had your period? \_\_\_\_\_

How many days does your period last? \_\_\_\_\_

How many days from the first day of one period to the first day of the next? \_\_\_\_\_

How would you describe your flow?  Normal  Light  Spotting only  
 Heavy  Heavy with clots  Heavy with flooding

How would you describe the regularity of your cycle?  
 Regular  Spotting between periods  Bleeding between periods

## Preventive Care

When was your last Pap Smear? \_\_\_\_\_

Have you ever had an abnormal Pap Smear?  No  Yes

When was your last mammogram? \_\_\_\_\_

## Sexual History

Are you sexually active?  Yes, with men  Yes, with women  Yes, with men and women  No

What type(s) of contraception do you currently use? \_\_\_\_\_

What methods of contraception have you used in the past? \_\_\_\_\_

Have you ever had a sexually transmitted disease?  No  Yes

If yes, please indicate type(s):  Gonorrhea  Chlamydia  Genital warts  Herpes  
 Hepatitis B  Trichomonas  Syphilis  Hepatitis C

## Habits/Exposures

Do you use tobacco products?  I never have  I currently do  I used to, but quit in \_\_\_\_\_

If you currently use or used to use tobacco products, when year did you begin using them? \_\_\_\_\_

What type(s) do you currently use/did you used to use?

Cigarettes; indicate packs/day \_\_\_\_\_  Cigars  Other: \_\_\_\_\_

Are you exposed to second hand smoke?  No  Yes

Do you use alcohol?  No  Yes

If yes, how many drinks per day do you consume? \_\_\_\_\_ What type(s) of alcohol do you consume? \_\_\_\_\_

Do you use any illicit substances?  No  Yes If yes, which ones do you use? \_\_\_\_\_

Do you have any of the following risk factors? (Check all that apply)

IV drug use  Multiple blood transfusions  Partner with HIV  
 Partner with Hepatitis B  Partner with Hepatitis C

How many caffeinated beverages do you consume each day? \_\_\_\_\_

How many times per week do you exercise? \_\_\_\_\_ Type(s) of exercise: \_\_\_\_\_

Do you feel safe at home?  No  Yes

Are you currently being hit, punched, kicked, or slapped by anyone?  No  Yes

Do you need to discuss violence at home with your provider?  No  Yes

## Medical History

Check any of the following medical conditions that you currently have or have had in the past:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Abnormal Heart Rhythm    | <input type="checkbox"/> Fibromyalgia                | <input type="checkbox"/> Ovarian Cysts                      |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Frequent Bladder Infections | <input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS) |
| <input type="checkbox"/> Anesthetic Complications | <input type="checkbox"/> Heart Disease               | <input type="checkbox"/> Premenstrual Syndrome (PMS/PMDD)   |
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Psychiatric Care                   |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Hernia                      | <input type="checkbox"/> Respiratory Disease                |
| <input type="checkbox"/> Autoimmune Condition     | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Seasonal Allergies                 |
| <input type="checkbox"/> Bleeding Disorder        | <input type="checkbox"/> High Cholesterol            | <input type="checkbox"/> Seizures                           |
| <input type="checkbox"/> Blood Clots              | <input type="checkbox"/> Infertility                 | <input type="checkbox"/> Sleeping Problems                  |
| <input type="checkbox"/> Blood Transfusions       | <input type="checkbox"/> ITP/Platelet Disorder       | <input type="checkbox"/> Stomach/Bowel Problems             |
| <input type="checkbox"/> Brain Injury/Problem     | <input type="checkbox"/> Kidney Disease              | <input type="checkbox"/> Stroke                             |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Kidney Stones               | <input type="checkbox"/> Thyroid Disorder                   |
| Type: _____                                       | <input type="checkbox"/> Liver/Gallbladder Problems  | <input type="checkbox"/> Ulcerative Colitis/Crohn's Disease |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Lupus                       | <input type="checkbox"/> Urinary/Fecal Incontinence         |
| <input type="checkbox"/> DES Exposure             | <input type="checkbox"/> Migraine Headaches          | <input type="checkbox"/> Uterine Fibroids                   |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Mitral Valve Prolapse       | <input type="checkbox"/> Other: _____                       |
| <input type="checkbox"/> Eating Disorder          | <input type="checkbox"/> Nose/Mouth/Throat Problems  |   |
| <input type="checkbox"/> Endometriosis            | <input type="checkbox"/> Obesity                     |   |
| <input type="checkbox"/> Eye/Ear Problems         | <input type="checkbox"/> Osteoporosis                |   |

## Surgical History

Have you had any of the following surgeries? (*Check all that apply*)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Abnormal Pap/Cervical Dysplasia Surgery | <input type="checkbox"/> Endometriosis Surgery  | <input type="checkbox"/> Nose/Mouth/Throat Surgery      |
| <input type="checkbox"/> Abnormal Uterine Bleeding Surgery       | <input type="checkbox"/> Eye Surgery            | <input type="checkbox"/> Orthopedic (Bone/Joint) Repair |
| <input type="checkbox"/> Appendectomy                            | <input type="checkbox"/> Fibroid Removal        | <input type="checkbox"/> Ovarian Surgery                |
| <input type="checkbox"/> Brain Surgery                           | <input type="checkbox"/> Gallbladder Removal    | <input type="checkbox"/> Plastic/Reconstructive Surgery |
| <input type="checkbox"/> Breast Augmentation                     | <input type="checkbox"/> Heart Surgery          | <input type="checkbox"/> Spine Surgery                  |
| <input type="checkbox"/> Breast Biopsy/Lumpectomy                | <input type="checkbox"/> Hysterectomy           | <input type="checkbox"/> Stomach/Bowel Surgery          |
| <input type="checkbox"/> Breast Reduction                        | <input type="checkbox"/> Hysteroscopy           | <input type="checkbox"/> Tubal Ligation                 |
| <input type="checkbox"/> Cerclage Placement                      | <input type="checkbox"/> Kidney/Bladder Surgery | <input type="checkbox"/> Urine Leakage Surgery          |
| <input type="checkbox"/> Cesarean Section                        | <input type="checkbox"/> Laparoscopy            | <input type="checkbox"/> Other: _____                   |
|  | <input type="checkbox"/> Mastectomy             |   |

## Family History

Check any of the following conditions that a family member currently has or has had in the past, then indicate who in your family has/had the condition.

- |   |  |
|---|--|
| <input type="checkbox"/> Breast Cancer _____            | <input type="checkbox"/> Colon Polyps _____        |
| <input type="checkbox"/> Cervical Cancer _____          | <input type="checkbox"/> Depression _____          |
| <input type="checkbox"/> Colon Cancer _____             | <input type="checkbox"/> Diabetes _____            |
| <input type="checkbox"/> Lung Cancer _____              | <input type="checkbox"/> Heart Disease _____       |
| <input type="checkbox"/> Ovarian Cancer _____           | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Pancreatic Cancer _____        | <input type="checkbox"/> High Cholesterol _____    |
| <input type="checkbox"/> Skin Cancer _____              | <input type="checkbox"/> Kidney Disease _____      |
| <input type="checkbox"/> Uterine Cancer _____           | <input type="checkbox"/> Osteoporosis _____        |
| <input type="checkbox"/> Alcoholism _____               | <input type="checkbox"/> Psychiatric Care _____    |
| <input type="checkbox"/> Arthritis _____                | <input type="checkbox"/> Respiratory Disease _____ |
| <input type="checkbox"/> Asthma _____                   | <input type="checkbox"/> Seizures _____            |
| <input type="checkbox"/> Anesthetic Complications _____ | <input type="checkbox"/> Stroke _____              |
| <input type="checkbox"/> Birth Defects _____            | <input type="checkbox"/> Thyroid Disease _____     |
| <input type="checkbox"/> Bleeding Disorder _____        | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Blood Clots _____              |  |

## Obstetric History

How many pregnancies have you had? \_\_\_\_\_

How many living children do you have? \_\_\_\_\_

How many of your deliveries were full term (after 37 weeks)? \_\_\_\_\_

How many of your deliveries were premature (20-37 weeks)? \_\_\_\_\_

How many c-sections have you had? \_\_\_\_\_

How many miscarriages have you had? \_\_\_\_\_

How many elective abortions have you had? \_\_\_\_\_

How many ectopic/tubal pregnancies have you had? \_\_\_\_\_

How many sets of twins or triplets have you had? \_\_\_\_\_

Have you had any complications during past pregnancies?  No  Yes

If yes, please mark all complications:

- |   |   |  |  |   |
|---|---|--|--|---|
| <input type="checkbox"/> Breech               | <input type="checkbox"/> Bleeding                       | <input type="checkbox"/> Premature labor | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Premature delivery |
| <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Premature rupture of membranes | <input type="checkbox"/> Other _____     |  |   |