

# Women's Healthcare Associates, LLC

## REVIEW OF MEDICAL HISTORY

### Adolescent Health Visit

Please answer the following questions

Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

By what name do you like to be called? \_\_\_\_\_

Do you want a female attendant in your room during your exam? Y N

Referred by \_\_\_\_\_

#### **Menstrual History**

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

What was the first day of your most recent period? \_\_\_\_\_

Are your periods regular? \_\_\_\_\_

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

How many days do you flow? \_\_\_\_\_ How heavy do you flow? \_\_\_\_\_

Are your periods painful? Y N

If yes:

Do you miss school? Y N How many days? \_\_\_\_\_

Do you miss other activities? Y N

Does anything make the pain better? \_\_\_\_\_

Does anything make the pain worse? \_\_\_\_\_

Any changes in your bowel movements with your periods? Y N

Have they always been painful? Y N

Do you have PMS symptoms? Y N

If yes, circle all that apply: bloating, headaches, food cravings, change in appetite, feeling tired, breast tenderness, crying, sadness, irritability, depression, overly sensitive, withdrawing from family and friends

Does your mother or sister(s) have menstrual problems? Y N

#### **Medical History**

Do you have any allergies to medications? Y N If so, please list here:

\_\_\_\_\_  
\_\_\_\_\_

Are you currently taking any medication? Y N If so, please list regular meds (including over the counter drugs):

\_\_\_\_\_  
\_\_\_\_\_

Have you had the HPV vaccine series? Y N Not sure

Have you had Hepatitis B vaccine series? Y N Not sure

Are you currently seeing a therapist? Y N If yes, who do you see?

\_\_\_\_\_  
\_\_\_\_\_

Have you ever received medication for depression? Y N

If yes, what? \_\_\_\_\_

**Surgery**

*Please list date and nature of hospitalization below.*

**Operations**

**Hospitalization for illness or injury**

- |          |          |
|----------|----------|
| 1) _____ | 1) _____ |
| 2) _____ | 2) _____ |
| 3) _____ | 3) _____ |

Do you have any chronic or serious illnesses?      Y   N

If yes, please list: \_\_\_\_\_

**General Physical Condition or Problems**

***Do you have any problems with any of the following? If yes, please list below.***

- |                                       |   |   |  |   |   |
|---------------------------------------|---|---|--|---|---|
| Hearing, Eyes, Ears, Nose, Throat     | Y | N | Hepatitis or any kind of liver ailment or jaundice | Y | N |
| Heart problems or high blood pressure | Y | N | Kidney or bladder problems/leaking of urine        | Y | N |
| Lung problems/Asthma/Bronchitis       | Y | N | Anemia/blood disorder/transfusion                  | Y | N |
| Breast lumps/pain/nipple discharge    | Y | N | Thyroid problems/diabetes/other endocrine problems | Y | N |
| Stomach/bowel/gall bladder problems   | Y | N | Headaches/migraines/nervous disorder               | Y | N |
| Varicose veins or phlebitis           | Y | N | Chicken Pox  | Y | N |

Other \_\_\_\_\_  
\_\_\_\_\_

**Family History**

***Who in your family have any of the following?***

- |                     |   |   |       |   |   |   |       |
|---------------------|---|---|-------|---|---|---|-------|
| High Blood Pressure | Y | N | _____ | Breast Cancer or Breast Disease           | Y | N | _____ |
| Stroke              | Y | N | _____ | Colorectal Cancer                         | Y | N | _____ |
| Heart Problems      | Y | N | _____ | Ovarian Cancer                            | Y | N | _____ |
| Kidney Problems     | Y | N | _____ | Hepatitis/TB/any other infectious disease | Y | N | _____ |
| Diabetes            | Y | N | _____ | Bleeding Disorders                        | Y | N | _____ |

Other \_\_\_\_\_  
\_\_\_\_\_

Do you have any other issues you wish to discuss?      Y   N

Please list here:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_