Female History Form

Client Name: _____ Age: _____ DOB: ___/____/_____

Primary Phone: _____ Maiden name/other names used in clinic:_____

Are you allergic to any medications, foods, latex, metals, or other? ❑ Yes ❑ No

Please list allergies:_____

Reason for visit today or concerns:_____

Current Medications: _____

_____

_____

FAMILY HISTORY

Are you adopted? ❑ Yes ❑ No *(If yes and you do not know your family history, you are done 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)

Relationship to you

Diabetes……❑ Yes _____ ❑ No ❑ Don't Know

High cholesterol / triglycerides….❑ Yes _____ ❑ No ❑ Don't Know

Sickle Cell Anemia……..❑ Yes _____ ❑ No ❑ Don't Know

Cancer ……..❑ Yes _____ ❑ No ❑ Don't Know *If yes, type:*_____

High blood pressure……❑ Yes _____ ❑ No ❑ Don't Know

Stroke……❑ Yes _____ ❑ No ❑ Don't Know

Phlebitis or clots in the veins ……❑ Yes _____ ❑ No ❑ Don't Know *If yes, what age?* _____

Heart disease or heart attack……❑ Yes _____ ❑ No ❑ Don't Know *If yes, what age?* _____

GENERAL HEALTH

Have you ever had or do you have:	YES	NO	Have you ever had or do you have:	YES	NO
Diabetes / Thyroid Problems			Problems with your kidneys or bladder		
Seizures			Cancer		
Heart attacks or strokes			High blood pressure		
Breast surgery or problems			Hepatitis (skin turned yellow) or gallbladder problems		
Depression			Pelvic infection treated in the hospital		
Migraines with aura			Uterine fibroids or ovarian cysts		
Blood Clot in your blood vessels like leg or lung			Problems with vision or hearing		
Blood transfusions			Eczema or skin problems		
Shortness of breath			Problems with muscles / bones		
Anemia			Cholesterol		

Have you ever had any other medical conditions, any surgery or been hospitalized? ❑ Yes ❑ No If yes, explain:_____

_____

_____

_____

Female History Form

PUBLIC HEALTH Franklin COUNTY KANSAS EST. 1855

SOCIAL HISTORY

- How many times a week do you exercise? _____
- Per day, how many fruits_____ vegetables_____ dairy_____ grains_____ meat _____ do you eat?
- Do you chew / smoke tobacco? ❑ Yes ❑ No If yes how many cigarettes a day? _____
- How long have you chewed / smoked? _____
- How many alcoholic beverages do you drink per day_____, week_____, month_____?
- Are you worried about your alcohol use? ❑ Yes ❑ No
- Do you currently use street drugs? ❑ Yes ❑ No If yes how many times a week?_____
- Do you or have you used injectable drugs? ❑ Yes ❑ No If yes, how often?____ Last time used? _____
- List the medications you are taking, how often and how much. *Include prescriptions, over the counter (Ibuprofen, Tylenol), herbs, & vitamins:*_____

  _____
- The date of your last mammogram_____ and results? _____
- If age 50 or older, have you had colon cancer screening? ❑ Yes ❑ No

MENSTRUAL

- How old were you when your periods began? _____
- Date of last period (1st day) _____
- Is your period overdue? ❑ Yes ❑ No
- How many days do your periods last? _____
- How many days from the start of one period until the start of the next period? _____
- Do you bleed between periods? ❑ Yes ❑ No
- How many pads/tampons do you use per day? _____
- Do you have pain with your periods? ❑ Yes ❑ No
- If yes, what do you do to relieve this pain?

  _____
- Do you have menstrual tension, weight gain, backache, or mood changes before your period? ❑ Yes ❑ No

PAP SMEARS

Is this your first Pap Smear? ❑ Yes ❑ No *(If this is your first pap smear, skip this section)*

When was your last Pap Smear? _____ What were the results? ❑ Normal ❑ Abnormal ❑ Do not know

If you have ever had an abnormal Pap Smear when and what treatment? _____

PREGNANCY

Have you ever been pregnant? ❑ Yes ❑ No *(If no, you are done with this section)*

- Age at first pregnancy: _____
- Number # of pregnancies: _____
- Number of deliveries: _____
- Date of your last delivery: _____
- Number of living children: _____
- Number of miscarriages: _____
- Number of abortions: _____
- Number of ectopic/tubal pregnancies: _____
- Describe any complications you had during pregnancy *(example: high blood pressure; depression; high blood sugars):*

  _____

  _____

CONTRACEPTIVES

Check all of the birth control methods you have used:

❑ Abstinence (not having sex)
❑ Foam, suppository, gel, film
❑ Diaphragm
❑ IUD
❑ Vaginal ring
❑ Pill
❑ Withdrawal
❑ Depo Provera
❑ Sponge
❑ Natural Family Planning
❑ Sterilization
❑ Condoms
❑ Norplant / Implanon
❑ Birth Control Patch
❑ Other_____

Female History Form

- What is the most recent birth control method you have used? _____
- Are you using this method now? ❑ Yes ❑ No
  - If yes, how long have you been using it? _____
  - If no, when did you stop using it? _____
- Have you had problems with any birth control methods? ❑ Yes ❑ No
  - If yes, describe_____

SEXUAL

- How old were you when you first had intercourse? _____
- When you were young did someone ever put something in your vagina? ❑ Yes ❑ No
- Are you experiencing any pain, discomfort or bleeding with or after intercourse? ❑ Yes ❑ No If yes, describe:

  _____
- Have you recently been treated for a vaginal infection? ❑ Yes ❑ No If yes, describe_____
- Do you have any symptoms of vaginal infection, such as itching, burning, odor, or unusual discharge? ❑ Yes ❑ No (list) _____
- Have you been treated for a sexually transmitted disease in the last year? ❑ Yes ❑ No What_____
- Have you been treated for a pelvic inflammatory infection in the last year? ❑ Yes ❑ No If yes, when?_____
- Have you had a new sexual partner or more than one sexual partner in the last year? ❑ Yes ❑ No
- How many partners in your lifetime? _____ How many partners have you had in the last year? _____
- When was your last sexual encounter?_____
- Were/Are your sexual partners:

  ❑ men ❑ women ❑ both ❑ IV drug users ❑ partner with multiple partners or at risk for HIV/STD
- What types of sex have you had? ❑ Oral ❑ Anal ❑ Vaginal ❑ None
- Have your ever been physically abused (hit, kicked, slapped)? ❑ Yes ❑ No
- Have you ever been emotionally abused (threatened, made to feel worthless)? ❑ Yes ❑ No
- Has anyone, including partner or family member ever forced you to have sex? ❑ Yes ❑ No
- What do you do to protect yourself from being infected with HIV/STD? _____

PSYCHOSOCIAL

- Do you have any problems at home, work, or school that are bothering you? ❑ Yes ❑ No If yes, please explain:

  _____
- During the past 2 weeks, have you been feeling down, depressed, irritable or hopeless?_____
- During the past 2 weeks, have you had little interest or pleasure in doing things? _____
- During the past 2 weeks, have you felt like harming yourself or others? _____
- Are you in a relationship with a person who threatens or physically hurt by someone? _____
- In the past year, have you been slapped, kicked, or otherwise physically hurt by someone?_____
- Have you been forced into sexual relations when you were not willing?_____

_____ _____

Client Signature ***Date***

For office use only

Summary of Findings / Recommendations / Referrals:

_____

_____

_____