Please Print
Date: ___________________

CENTRAL HEALTH CENTER
FEMALE MEDICAL HISTORY

PATIENT #__________________

Patient Name: ______________________________ Date of Birth: ______________ Age: _______
Reason for Visit: ______________________________ Occupation: ______________________
______________________________ Are you a student: Yes ☐ No ☐
Marital Status: S M D W Separated ❒ Living with someone ❒ Highest grade in school completed ______________

YES	NO	
		Family MD: ______________________
☐	☐	Are you receiving medical care with another provider? Reason for visit(s)__________________
☐	☐	Allergic to any medications, latex, metals or anesthesia? List: ______________________
☐	☐	Currently taking any medications? (Including herbal remedies and vitamins)? List: ______________
☐	☐	Are you compliant with taking prescribed medications?

FAMILY HISTORY

YES	NO	N/A	
☐	☐		Are you adopted?
☐	☐	☐	Did your mother take DES while she was pregnant with you (if you were born before 1971)?

Does your Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM), Grandfather (GF), have any of the following?

YES	NO		WHO
☐	☐	Mother or Sister pregnant before age 18?	________
☐	☐	Hypertension (High Blood Pressure)	________
☐	☐	High Cholesterol	________
☐	☐	Stroke or Heart Attack (If yes, age?)	________
☐	☐	Blood Clots	________
☐	☐	Diabetes	________
☐	☐	Cancer	________
☐	☐	Osteoporosis	________
☐	☐	Died before 50 years old	________
☐	☐	Does any other condition run in your family?	________
☐	☐	Did any of your natural family members have birth defects?	________
☐	☐	Other ______________	________

PERSONAL HISTORY

Have **You Ever** been told by a doctor you had any of the following?

YES	NO		STAFF
☐	☐	Cancer	________
☐	☐	Genetic Condition	________
☐	☐	Heart Attack / Serious Heart Valve Problems	________
☐	☐	Hypertension (High Blood Pressure)	________
☐	☐	Stroke	________
☐	☐	High Cholesterol / Triglycerides	________
☐	☐	Blood Clots in legs, etc. (Thrombophlebitis)	________
☐	☐	Varicose Veins	________
☐	☐	Anemia (low iron) / Sickle Cell Anemia	________
☐	☐	Blood Clotting Disorder	________
☐	☐	Blood Transfusion(s)	________
☐	☐	Migraine Headaches : If yes do you have	________
		☐ vision changes (**not** including light sensitivity)	________
		☐ numbness / weakness / tingling of arms / legs	________
		☐ speech problems	________
☐	☐	Seizures / Epilepsy / Benign Brain Tumor	________
☐	☐	Diabetes / Gestational Diabetes (w/preg.)	________
☐	☐	Thyroid problems	________
☐	☐	Asthma / Chronic Cough / TB	________
☐	☐	Breast cancer or Lump / Mass / Discharge	________
☐	☐	Breast Surgery	________
☐	☐	Liver Disease / Hepatitis / Mono	________
☐	☐	Gall Bladder Disease	________
☐	☐	Colitis / Irritable Bowel Syndrome	________
☐	☐	Frequent Vaginal Infections	________
☐	☐	PID (Pelvic Inflammatory Disease)	________
☐	☐	Abnormal Pap Smear	________
☐	☐	Cervical Colposcopy (Colpo)	________
☐	☐	Cervical Cryo / LEEP / Laser / Cone	________
☐	☐	Bladder Problems / Infections	________
☐	☐	Kidney Problems / Infections	________
☐	☐	Arthritis	________
☐	☐	Broken Bones/Fractures	________
☐	☐	Jaundice (yellowing of the skin)	________
☐	☐	Cold Sores or Fever Blisters	________
☐	☐	Severe Depression / Anxiety	________
☐	☐	Eating Disorder	________
☐	☐	Past Surgery(s) / Hospitalization(s)	________

Comments ______________________________________
____
____

REVIEW OF SYSTEMS - Do You Now have:

YES	NO		
		Constitutional	
☐	☐	Generally healthy	________
☐	☐	Recent weight gain or loss ≥ 10 lbs.	________
☐	☐	Frequent cold, flu, etc.	________
☐	☐	Chronic severe fatigue (>6 mos)	________
		Cardiovascular	
☐	☐	Chest pain / pressure	________
		Hematological	
☐	☐	Redness / swelling in legs/arms	________
		Neurological	
☐	☐	Numbness / Sensory loss	________
☐	☐	Headaches, If yes do you ever have any of these with or before headaches:	________
	☐	vision changes (**not** including light sensitivity)	________
	☐	numbness / weakness / tingling of arms / legs	________
	☐	speech problems	________
		Chest/Breast	
☐	☐	Breathing problems / shortness of breath	________
☐	☐	Breast pain / lump / discharge	________
		Gastrointestinal	
☐	☐	Severe abdominal pain	________
☐	☐	Nausea / vomiting / diarrhea / constipation	________
☐	☐	Rectal bleeding	________
		Genitourinary	
☐	☐	Burning with urination	________
☐	☐	Abnormal vaginal discharge / bleeding	________
☐	☐	Pelvic pain or pain with sex	________
☐	☐	Vaginal sores / blisters / bumps	________
		Musculoskeletal	
☐	☐	Severe pain in arms / legs / joints	________
		Skin	
☐	☐	Yellowing of the skin	________
☐	☐	Acne	________
☐	☐	Rash / Itching	________
☐	☐	Blisters / lesions / other skin problems	________
		HEENT	
☐	☐	Yellowing of the eyes	________
☐	☐	Blurred or double vision	________
☐	☐	Earache / pain / hearing problems	________
☐	☐	Frequent nose bleeds	________
☐	☐	Sore throat / trouble swallowing	________
☐	☐	Tooth / gum problems	________
		Psych	
☐	☐	Severe Mood Swings / Anxiety / Sadness	________

MENSTRUAL HISTORY

When was the 1st day of your last period? ________________
Was it normal? ☐ Yes ☐ No
Age when periods first started: ________________
Periods are: ☐ Regular ☐ Irregular ☐ Painful
Flow is: ☐ Light ☐ Moderate ☐ Heavy
Periods come every_________ days. Bleeding lasts_________days.
If you are no longer having periods, it is because of:
☐ Depo ☐ Menopause ☐ Hysterectomy ☐ Other ________
Problems with periods: ______________________________

STD HISTORY

Do You or Have you ever had the following? Check all you have or had.

☐ Chlamydia ☐ Syphillis ☐ Trichomonas
☐ Gonorrhea ☐ HPV/Warts ☐ Hepatitis
☐ Herpes ☐ Molluscum ☐ HIV

Dates / Treatment ______________________________

VACCINE (SHOTS) HISTORY

YES	NO	Unsure	
☐	☐	☐	Measles/Rubella shot (usually get by age 5)
☐	☐	☐	Tetanus vaccine (shot) in the last 10 years
☐	☐	☐	Hepatitis B shots (a series of 3 shots)
☐	☐	☐	Gardasil / Cervarix (a series of 3 shots)

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Patient Name: ____________________

Patient Number: ____________ **Date of Birth:** ________

PREGNANCY HISTORY / PLANS

Number of times pregnant ____ ☐ Never Pregnant
Number of Live Births ____ Date(s) ________
Number of C-Sections ____ Date(s) ________
Number of Premature Births ____ Date(s) ________
Number of Miscarriages ____ Date(s) ________
Number of Still Births ____ Date(s) ________
Number of Ectopics (tubal) ____ Date(s) ________
Number of Abortions ____ Date(s) ________
Number of Living Children ____ Date(s) ________
Number of Adoptions ____ Date(s) ________

Have **you** had any of the following problems with a pregnancy?
☐ Gestational Diabetes ☐ Preterm Labor ☐ Genetic Abnormalities
☐ High Blood Pressure ☐ Other________

Are you currently breastfeeding? ☐ Yes ☐ No
Are you planning a pregnancy in the next 12 months? ☐ Yes ☐ No
Are you planning a pregnancy in the next 1-3 years? ☐ Yes ☐ No
Are you planning a pregnancy in the next 3-5 years? ☐ Yes ☐ No
Are you planning a pregnancy in the next 5-10 years? ☐ Yes ☐ No

Are you concerned that you are pregnant?

Can we assist you with information on planning your family (Reproductive Life Plan)? ☐ Yes ☐ No

CONTRACEPTIVE HISTORY - Check all that apply

Now	Past	Method	Now	Past	Method
☐	☐	Pill Type:________	☐	☐	Diaphragm
☐	☐	Depo Provera	☐	☐	Tubal Ligation
☐	☐	Lunelle	☐	☐	Vascectomy
☐	☐	Patch	☐	☐	Rhythm / Natural
☐	☐	Ring	☐	☐	Cervical Cap
☐	☐	Condom	☐	☐	Female Condom
☐	☐	Abstinence	☐	☐	Foam / Sponge / Film
☐	☐	IUD	☐	☐	Implanon

When did you last use your method? ________
Comments or problems with method(s): ________

Do you want a birth control method or information on preventing pregnancy today?
Yes ☐ No ☐ If yes, what? ________

Have you had sex without birth control since your last period? ☐ Yes ☐ No
If yes, when? ________ Time:________

HEALTH HABITS Fill in **all** the blanks

How often do you:

Do Self Breast Exams ________
Exercise ________
Drink Water: # 8 ounce glasses ______ per day
Multivitamin ________
Take a Calcium Supplement ________
Douche ________
Wear Seat Belts ________
Drink Caffeine: #________ per day
Smoke: #________ cigarettes per day
Drink Alcohol: #________ per week
Use Street Drugs ________
IV Needles ________

How many do you eat a day:

Fruit ________
Vegetables ________
Eggs / Meat ________
Milk / Dairy ________

SEXUAL HISTORY

YES	NO	N/A	
☐	☐	☐	If 18 or younger; are your parents aware of this visit?
☐	☐		Are you sexually active? ☐ Vaginal ☐ Oral ☐ Anal
☐	☐		Are your sexual partner(s): ☐ Male ☐ Female ☐ Both
☐	☐		Age at 1st sexual contact ________ Was it by: ☐ Choice ☐ Force ☐ Coercion ☐ Molestation

How long have you been with your current partner? ________
Total number of partners in the: last 3 months ________ past 12 months ________ Lifetime________

YES	NO	N/A	
☐	☐	☐	Have you had sex since your last menstrual period?
☐	☐		Do you use condoms with sex every time?
☐	☐		Have you had difficulty becoming pregnant?
☐	☐		Do you have questions/ concerns about sex?
☐	☐		**Request testing for sexually transmitted infections?**

PARTNER(S) HISTORY

How many partners has your partner had before you?________
Have you ever had a partner who:

YES	NO	Unsure	
☐	☐	☐	Is bisexual?
☐	☐	☐	Has / had multiple partners?
☐	☐	☐	Is / was at risk for STIs and / or HIV?
☐	☐	☐	Uses / used needles or IV street drugs?

PSYCHOSOCIAL HISTORY

YES	NO	
☐	☐	Do you have severe emotional/ relationship problems?
☐	☐	Does someone hit, slap, kick or hurt you?
☐	☐	Does someone force you to have sex?
☐	☐	Are you afraid of your partner?
☐	☐	Do alcohol and/or other drugs cause problems in your life?
☐	☐	Are others concerned with your alcohol/ drug habits?
☐	☐	Do you have difficulty in sleeping?
☐	☐	Do you experience trauma or violence?
☐	☐	Do you receive counseling?

Do Not Fill Out or Sign Anything Below This Line

Education:

Breast Self-Exam	☐	Abstinence / Resisting Sexual Pressure	☐	ABC's	☐
Available Contraceptive Methods	☐	Folic Acid	☐	Patient Rights & Responsibilities	☐
Sexually Transmitted Diseases	☐	Rubella	☐	Notice of Privacy Practices	☐
Pap Smear Fact Sheet	☐	Smoking	☐	Your Clinic Visit	☐
Family Involvement	☐	DES (Born between 1940-75)	☐	Relationship Check Form	☐
Emergency Contraception	☐	HIV	☐	Nutrition	☐
Sexual Health Assessment	☐	Hepatitis Information	☐	Other:________	

To the best of my knowledge, the above history is complete and accurate. I understand the educational information given to me. I have been given an opportunity to ask questions. If I am 18-years-old or younger, I have been strongly encouraged to discuss my family planning needs with my parents and I have received information on abstinence and how to resist sexual pressure. If I smoke, I have been given information and understand the health risks of smoking. I have been told that if tests are taken for sexually transmitted diseases (STD), reporting of positive results to public health agencies is required by law. I understand that Nebraska Health and Human Services may access my medical record to determine the quality of services provided by this agency.

CONSENT TO TREATMENT: I hereby consent to examination, consultation, testing, including HIV testing, and treatment at this clinic.

If I do not want tested for HIV, I will notify personnel at CHC that I do not want tested for HIV. ☐ **Waiver Form Signed**

(DO NOT SIGN UNTIL INSTRUCTED BY STAFF AS WITNESS)

Patient Signature ____________ Staff Signature ____________ Date ________

ASSURANCE OF CONFIDENTIALITY:

This medical record is confidential and will not be released to anyone without your written consent except as may be required by law.

CHC FP4 7/10
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