Internal Use Only:
MCIR: ☐Yes ☐No

FEMALE HEALTH HISTORY

Name: _____ DOB: _____ Age: _____
First Middle Initial Last MM / DD / YY

GENERAL HISTORY	YES	NO
Are you being treated for any illness, disease, or condition now? If yes, specify: _____		
Have you ever received the Gardasil (HPV) vaccine?		
Have you had any surgery? If yes, specify:_____		
Do you have any allergies? If yes, specify: _____		
Have you had cancer or meningioma?		
Do you have any birth defects or inherited genetic problems?		

CARDIOVASCULAR HISTORY	YES	NO
Any serious heart or heart valve problems?		
Stroke or stroke-like symptoms?		
Blood clot or blood clotting disorder?		
High blood pressure?		
Increased cholesterol?		
Anemia?		
Sickle cell disease or trait?		

RESPIRATORY HISTORY	YES	NO
Asthma or breathing problems?		
Tuberculosis (TB) or exposure to TB?		

GASTROINTESTINAL HISTORY	YES	NO
Stomach or bowel problems?		
Liver problems? (including hepatitis)		
Gallbladder disease?		

GENITOURINARY HISTORY	YES	NO
Vaginal discharge problems?		
Bladder or kidney problems?		
Problems with your uterus?		
Problems with your ovaries?		
Infection of your tubes/uterus/PID?		
Breast lump or breast surgery?		
Have you ever had a mammogram? Most recent date: ____ Was it normal? Y N		
Have you ever had a pelvic exam? Most recent date: ____ Was it normal? Y N		
Have you ever had a Pap test? Most recent date: ____ Was it normal? Y N		

ENDOCRINE HISTORY	YES	NO
Thyroid problems?		
Diabetes?		

MENSTRUAL HISTORY	YES	NO
Have you had unprotected sex (without a condom) after your last period?		
Do you have regular monthly cycles? If not, how often? _____		
How many days do your periods last?_____		
During your period are your cramps mild ___, moderate ___, or severe ___?		
Do you have little ___, moderate ___, or heavy ___ bleeding during your period?		
Do you have bleeding after sex?		
Do you have bleeding between periods?		
Any changes in your period in the last year?		

SEXUAL HISTORY	YES	NO
Are you currently having sex? If yes, how long with current partner? _____ How many partners have you had in the last 12 months? _____ 2 months? _____		
Do you have sex with: Men:____ Women:____ Both:____ N/A:___		
Do you have any problems with sex?		
Age of first vaginal intercourse: _____		
Do you give/receive oral sex? (circle) Condoms: Never Sometimes Always		
Do you have vaginal sex? Condoms: Never Sometimes Always		
Do you have anal sex? Condoms: Never Sometimes Always		

HIV/STI RISK ASSESSMENT	YES	NO
Have you ever had a sexually transmitted infection? If yes, mark what and when:		
Chlamydia		
Gonorrhea		
Genital Warts		
Herpes		
Trichimoniasis		
Syphilis		
HIV/AIDS		

TURN OVER

FEMALE HEALTH HISTORY (CONTINUED)

CONTRACEPTIVE HISTORY	Used	Problems?
Tubal or vasectomy (circle)		
Birth Control Pill		
The Patch		
The Ring		
Implanon		
Depo-Provera (the shot)		
IUD, Mirena, or Paragard (circle)		
Condoms		
Diaphragm		
Withdrawal		
Rhythm/Natural Family Planning		

PREGNANCY HISTORY	YES	NO
Have you ever been pregnant?		
Are you planning a pregnancy in the next year?		
Number of pregnancies: _____		
Ages of living children: _____		
Date last pregnancy ended: _____		
Any complications of pregnancies? If yes, specify: _____		
Have you had any miscarriages?		
Have you had any abortions?		

NEUROLOGICAL/MENTAL HEALTH	YES	NO
Have you ever had seizures/epilepsy?		
Have you ever had severe long-term depression?		
Do you get headaches? If so, have you been diagnosed with migraine headaches? ____ With aura? ____		

ALCOHOL USE	YES	NO
Do you drink alcohol? How often? _____ How much? _____		

DRUG USE	YES	NO
Do you ever use recreational drugs? If yes, what kind? _____ How often? _____		

SOCIAL HISTORY	YES	NO
Have you ever been emotionally ____, physically ____, or sexually ____ abused?		
Do you feel safe at home? At school? If yes, please circle.		
Are you concerned about violence or abuse at home? With others? If yes, please circle.		

HEALTH MAINTAINENCE	YES	NO
Do you perform self breast exams every 1-3 months?		
Do you drink pop or juice? If yes, amount per day? _____		

HEALTH MAINTAINENCE CONT.	YES	NO
Do you add salt to your food?		
How many times per week do you eat fast food? _____		
Have you ever had an eating disorder?		
Are you happy with your weight? If no, what weight do you desire? _____		
Do you exercise on a regular basis? If yes, describe: _____		

FAMILY HISTORY	YES	NO
Is there any family history (immediate or extended) of breast cancer? If yes, who? _____		
Is there any family history (immediate or extended) of ovarian cancer? If yes, who? _____		
Has anyone in your immediate family had any of the following? If yes, specify if it is your mother, father, sister, or brother.		
High blood pressure		
High cholesterol		
Heart disease		
Heart attack		
Stroke		
Blood clot/Clotting disorder		
Diabetes		
Depression		
Suicide		
Cancer		
Substance/Alcohol abuse		

MEDICATIONS	YES	NO
Do you have allergies to any medications: Please list: _____		
Are you currently taking any medications? (Including prescriptions, over the counter drugs, and birth control) Please list: _____ _____ _____		

PREFERRED PHARMACY INFORMATION

*This is where we will send your prescriptions at the end of your visit (if applicable)

Name: _____

Address: _____

_____

Phone: _____