

NORTH SCOTTSDALE WOMEN'S HEALTH

Patient Medical History Form

| Name: | | Date of Birth: | Age: |
|---------------|------|---------------------------------|--|
| Today's date: | | Referred by: | |
| Test | Date | Results | |
| Bone Density | | <input type="checkbox"/> Normal | <input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Never had one |
| Colonoscopy | | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal <input type="checkbox"/> Never had one |
| Mammogram | | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal <input type="checkbox"/> Never had one |
| Pap Smear | | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal <input type="checkbox"/> Never had one |

Medical History

Have you ever had any of the following?

| | Age |
|---|-----|
| <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Freq Bladder Infections | |
| <input type="checkbox"/> Bleeding Problems | |
| <input type="checkbox"/> Blood Clots (Lungs/Legs) | |
| <input type="checkbox"/> Blood Transfusion | |
| <input type="checkbox"/> Chicken Pox | |
| <input type="checkbox"/> Cancer | |

| | |
|--|--|
| <input type="checkbox"/> Depression/Anxiety | |
| <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Epilepsy/Seizures | |
| <input type="checkbox"/> Gall Bladder Disease | |
| <input type="checkbox"/> Genetic Condition | |
| <input type="checkbox"/> Heart Disease/Attack | |
| <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> High Cholesterol | |
| <input type="checkbox"/> Kidney Infections | |
| <input type="checkbox"/> Liver Disease/Hepatitis | |

| | |
|--|--|
| <input type="checkbox"/> Migraines | |
| <input type="checkbox"/> Mitral Valve Prolapse | |
| <input type="checkbox"/> Pelvic Infections | |
| <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Sickle Cell Disease | |
| <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Thyroid Problem | |
| <input type="checkbox"/> | |
| <input type="checkbox"/> | |
| <input type="checkbox"/> | |

Surgical History

Please list all surgeries with dates:

| | | | | |
|--|--|--|--|--|
| | | | | |
| | | | | |
| | | | | |

List all medications you are currently taking.

| | | | |
|------------------------------------|--|--------------------|--------------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| List any allergies to medications: | | | |
| Other allergies: | | | |
| | | No known allergies | <input type="checkbox"/> |

Family History

Please list any close relatives with a history of the following:

| | Relative | | Relative |
|---|----------|---|----------|
| <input type="checkbox"/> Breast cancer | | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Colon cancer | | <input type="checkbox"/> Heart Disease (heart attack, stroke, bypass surgery) | |
| <input type="checkbox"/> Ovarian cancer | | <input type="checkbox"/> High blood pressure | |
| <input type="checkbox"/> Uterine cancer | | | |

Reproductive History

Check here if you've never been pregnant

Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopic (tubal), and abortions:

| Year | M/F | Type of Delivery | Length of Pregnancy | Problems (e.g., preterm labor, diabetes, high blood pressure) | Name/Age |
|------|-----|------------------|---------------------|---|----------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Age of first period: _____ Date of 1st day of last period: _____ Age of last period: _____

Periods are: Regular Irregular Painful Not really bothersome

Flow is: Light Moderate Heavy
 How freq do you get your period _____
 How many days does it last _____

Are you sexually active? Yes No Never

Sexual preference: heterosexual homosexual bisexual
 New partners since last exam? yes no

Method of Birth Control: condoms vaginal ring partner with vasectomy pills tubal/Essure
 natural family planning patch IUD none other

Have you ever had any of the following sexually transmitted disease (STDs)?

| | | | |
|--------------------------------------|--|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Herpes | <input type="checkbox"/> HPV |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Trichomonas | <input type="checkbox"/> Never had any | | |

Are you concerned you may have been exposed to a sexually transmitted disease? Yes No

Have you ever had any of the following?

Endometriosis Ovarian cysts Uterine fibroids

Have you ever needed any of the following for an abnormal pap?

Colposcopy Date _____ Cryo surgery Date _____ LEEP/Laser/Conization Date _____

Do you currently have any of the following? Frequent urination Burning with urination

Incontinence Urgency Vaginal discharge Irregular vaginal bleeding

Pelvic pain Painful intercourse Breast lumps

Social History

Single Married Separated Divorced Widowed

Alcohol use Yes No If yes, _____ drink(s) per day/week/month

Tobacco use Yes No Quit # of pack(s) per day _____ for _____ years

Street drugs Yes No Type and frequency _____

Exercise Yes No Type and frequency _____

Signature _____ Date _____