Associates in Women's Health, Inc.

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Confidential Health Record

In order for the doctors to give you the best medical care, they must have complete and accurate information concerning your past medical, surgical and obstetrical history. You are therefore requested to fill out both sides of this questionnaire as fully as possible.

Today's Date_____-_____-_____ Your Birth Date_____-_____-_____ Social Security # _____-_____-_____

Your Name_____ Age _____ Referred by (e.g. Physician, friend)_____

Address_____ City _____ State _____ Zip_____ Phone _____

Your Occupation_____ Employer_____ Phone_____

Husband / Partner's Name _____ Social Security # _____-_____-_____

His Employer _____ Address_____ Phone_____

Are you: ❑single ❑married ❑widowed ❑divorced ❑partnered No. of years married _____ No. of years partnered _____

Reason for Today's Visit _____

Your Medical History *(Check those which apply)*

❑ German Measles	❑ Diabetes	❑ Seizures	❑ Migraines
❑ Rheumatic Fever	❑ Tuberculosis	❑ Cancer	❑ Blood Clots
❑ Heart (e.g. mitral valve prolapse)	❑ Thyroid Disease	❑ Other: _____	
❑ Lung (e.g. asthma)	❑ High Blood Pressure	_____	
❑ Kidney Disease	❑ Varicose Veins / Phlebitis	❑ Drug Allergies _____	
❑ Psychiatric Disease	❑ Injuries	_____	
❑ Sexually Transmitted Disease	❑ Blood Transfusions	_____	
(e.g. herpes, venereal warts)	❑ Hepatitis (yellow jaundice)	_____	

Operations *(what kind & when)*

_____

_____

_____

_____

Non-Surgical Hospitalizations *(for what & when)*

_____

_____

_____

_____

Have you ever had a Pap test done? ❑ yes ❑ no If "yes", date of most recent Pap test: _____

Have you ever had an abnormal Pap test? ❑ yes ❑ no If "yes", when? _____

Do you use tobacco? ❑ yes ❑ no If "yes", how much? _____ per day. For how long? _____

Do you drink alcohol? ❑ yes ❑ no If "yes", how frequently? _____

Are you presently taking any medications? ❑ yes ❑ no If "yes", please list them: _____

_____

Family Physician _____ Phone _____

- over -

Your Menstrual History

Last menstrual period started on _____-_____-_____. Was it normal? ❑ yes ❑ no

Menstrual flow usually lasts _____ days. Menstruated for the first time at the age of _____.

Are you having regular menstrual cycles? ❑ yes ❑ no

If "yes", approximately how frequently do they occur? every _____ days

If "no", how often have they occurred in the last year?_____ times

Are you taking hormone replacement therapy? ❑ yes ❑ no

Are you currently experiencing any menopausal symptoms *(e.g. hot flashes, vaginal dryness, etc.)?* _____

_____

Are your periods painful? ❑ yes ❑ no If your periods are painful, are they: ❑ mild ❑ moderate ❑ severe ❑ incapacitating

Menstrual flow is: ❑ scant ❑ moderate ❑ heavy ❑ excessive *(heavy = 1 pad or tampon per hour)*

Are there any other symptoms associated with your periods? ❑ yes ❑ no If "yes", explain _____

_____

Do you have any bleeding or spotting: between periods? ❑ yes ❑ no; after intercourse? ❑ yes ❑ no

Contraceptives

Do you use a contraceptive? ❑ yes ❑ no If "yes", which method? _____ for how long?_____

Do you use a contraceptive: ❑ always ❑ most of the time ❑ occasionally

Does your partner use a contraceptive? ❑ yes ❑ no If "yes", which method? _____

History of All Previous Pregnancies

Include all full-term (9-month) pregnancies, miscarriages (indicate whether spontaneous or induced), premature deliveries or abortions in the order that they occurred.

Year	Sex	Birth Weight	# Months Pregnant	Wt. Gain	Duration of Labor	Anesthesia	Hospital	Complications

Your Family's Medical History *(Check, and specify relationship to you.)*

❑ Cancer: ❑ breast ❑ ovarian ❑ cervical ❑ uterine
❑ colon ❑ other _____
_____
_____

❑ Diabetes _____

❑ Heart Disease _____

❑ High Cholesterol _____

❑ High Blood Pressure _____

❑ Nervous Breakdown _____

❑ Mental Retardation or Birth Defects _____

❑ Congenital family diseases _____

Is there a history of twins in your family? ❑ yes ❑ no

When you have completed this form, please leave it with the receptionist. Thank you.