

MISSOULA WOMEN'S HEALTHCARE INITIAL HEALTH HISTORY FORM

Date: _____

Legal Name _____ Age _____ Date of Birth _____

Reason for your visit _____

GENERAL MEDICAL HISTORY

	none	self	mother	father	sibling	your child	grandparent	aunt/uncle
Alcoholism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arthritis/Lupus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liver disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seizure disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you smoke/use tobacco? No Yes How many per day? _____

Do you drink alcohol? No Yes How many drinks per week? _____

Do you use recreational/illegal drugs? No Yes What and how long? _____

What was the month and year of your last physical exam? _____

What the month and year of your last:

Pap Test _____ never / normal / abnormal - If abnormal Pap, did you have a colonoscopy? No Yes

Bone density _____ never / normal / abnormal Cholesterol _____ never / normal / abnormal

Colonoscopy _____ never / normal / abnormal Mammogram _____ never / normal / abnormal

Patient's Name _____ Date of Birth _____

No know drug allergies Allergic to latex Allergic to tapes/adhesives

Allergic to _____ Reaction _____

Allergic to _____ Reaction _____

What Medications do you take? (Include birth control/ hormones)

Prescription Medication

Dose, # of times/day

What is it for?

(If you take more than four prescription medications, please attach a separate sheet listing them)

Do you take a multivitamin? No Yes Calcium supplement? No Yes

OB/GYN. MEDICAL HISTORY

How old were you when you had your first period? _____

How many days from the first day of one period to the first day of the next one? _____

How many days do your periods last? _____

Are your periods regular? No Yes

Do you have cramps with your period? No Yes: mild moderate severe

Do you bleed or spot between periods? No Yes

Do you bleed after intercourse? No Yes

What was the first day of your last period, or if you are menopausal, when was your last period? _____

Do you have menopausal symptoms No Yes What? _____

How old were you when you first had sexual intercourse? _____

of sexual partners _____

Are you sexually active now? No Yes

If yes, is your partner Male Female

Do you use anything to keep from getting pregnant?

Are you trying to get pregnant? No Yes

If yes, what? (circle) Condoms DepoProvera Pill Patch Ring Tubal Ligation Vasectomy

 IUD inserted (date and type of IUD) _____ Diaphragm Spermicides Rhythm Withdrawal

Do you have: (circle) FIBROIDS E~IDOMETRIOSIS POLYCYSTIC OVARIES HIGH RISK HPV

Gardasil series dates: 1st injection _____ 2nd injection _____ 3rd injection _____

SUMMARY OF PREGNANCIES

of pregnancies _____ # of deliveries under 37 weeks _____ # of deliveries @ 37 + weeks _____

of miscarriages or abortions _____ # of living children _____