ADULT HISTORY: FEMALE

Date:_____

Patient Name:_____ DOB:_____

PAST MEDICAL HISTORY: (PMH)

- ☐ Unremarkable
- ☐ Abnormal Pap Smear
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune Disorder
- ☐ Blood Transfusions
- ☐ Brain Tumor
- ☐ Cataract
- ☐ Cancer - Breast
- ☐ Cancer – Cervical
- ☐ Cancer – Colon
- ☐ Cancer – Lung
- ☐ Cancer – Ovarian
- ☐ Cancer – Skin
- ☐ Cancer – Thyroid
- ☐ Chrohn's Disease
- ☐ Chronic Low Back Pain
- ☐ Cirrhosis
- ☐ Congestive Heart Failure
- ☐ Constipation, Chronic
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ CVA/Stroke
- ☐ Degenerative Joint Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes - Gestational
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Diverticulitis
- ☐ DES Exposure
- ☐ DVT (Clot)
- ☐ Eczema
- ☐ Fibromyalgia
- ☐ GERD (gastric reflux)
- ☐ Glaucoma
- ☐ GI Bleed
- ☐ Gout
- ☐ GYN – # of Pregnancies _____
- ☐ GYN - # of Deliveries _____
- ☐ GYN - # of Miscarriages _____
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Incontinence
- ☐ Infertility
- ☐ Inflammatory Bowel Disease
- ☐ Kidney Disease
- ☐ Kidney Stone
- ☐ Liver Disease
- ☐ Lupus
- ☐ Macular Degeneration
- ☐ Migraine Headache
- ☐ Multiple Sclerosis
- ☐ MI (Heart Attack)
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Peptic Ulcer Disease
- ☐ Polymylagia Rheumatica
- ☐ Psoriasis
- ☐ Polymylagia Rheumatica
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Tuberculosis
- ☐ Urinary Tract Infections, Recurrent
- ☐ Varicose Veins

GYN History:

Last Pap Smear Date:_____

☐Normal ☐Abnormal

Last Mammogram Date:_____

☐Normal ☐Abnormal

HPV (Gardasil) ☐Yes ☐No

Other: _____

ADULT HISTORY: FEMALE

Date:_____

Patient Name:_____ DOB:_____

PAST SURGICAL HISTORY: (PSH)

	DATE		DATE
☐ Unremarkable	_____	☐ Hernia – Incisional	_____
☐ Abdominal Aortic Aneurysm Repair	_____	☐ Hernia – Inguinal	_____
☐ Abdominal Surgery	_____	☐ Hernia – Umbilical	_____
☐ Amputation	_____	☐ Hernia – Ventral	_____
☐ Anesthesia Problem – No	_____	☐ Hysterectomy with tubes/ovaries removed	_____
☐ Anesthesia Problem - Yes	_____	☐ Hysterectomy without tubes/ovaries removed	_____
☐ Aortic Valve Replacement	_____	☐ Hysteroscopy	_____
☐ Appendectomy	_____	☐ Laminectomy	_____
☐ Aorto-Femoral Bypass	_____	☐ Lap Band Procedure	_____
☐ Arthroplasty – Total Hip Replacement	_____	☐ Lumpectomy (Breast lump removed)	_____
☐ Arthroplasty–Total Knee Replacement	_____	☐ Mastectomy ☐Right ☐Left ☐Bilateral	_____
☐ Arthroscopy – Scoping of Knee	_____	☐ Mitral Valve Replacement	_____
☐ Back Surgery	_____	☐ Kidney Transplant	_____
☐ Breast Biopsy	_____	☐ Pacemaker	_____
☐ Breast Surgery	_____	☐ Pacemaker with ICD Placement	_____
☐ Bronchoscopy (Scoping of Lungs)	_____	☐ Parathyroidectomy (Parathyroid Removed)	_____
☐ CABG – Coronary bypass surgery	_____	☐ Pneumonectomy (Lung Removed)	_____
☐ Caesarian Section	_____	☐ PTCA (Heart Stent)	_____
☐ Carotid Endarterectomy	_____	☐ Rotator Cuff Repair	_____
☐ Carpal Tunnel	_____	☐ Sinus Surgery	_____
☐ Cataract(s) Removed	_____	☐ Surgical Complication	_____
☐ Cholecystectomy (Gallbladder Removed)	_____	☐ Tonsillectomy	_____
☐ Cholecystectomy (Gallbladder Removed)	_____	☐ Tubal Ligation (tubes tied)	_____
☐ Colostomy	_____	☐ Urinary Incontinence Surgery	_____
☐ Craniotomy	_____	☐ Vascular Surgery	_____
☐ Gastric Bypass	_____	☐ Vein Stripping	_____
☐ Hemorrhoidectomy	_____		

Other: _____

Medications and How You Take Them (Include vitamins and herbals):

Name:_____ Strength:_____ Amount/day:_____
Name:_____ Strength:_____ Amount/day:_____
Name:_____ Strength:_____ Amount/day:_____
Name:_____ Strength:_____ Amount/day:_____
Name:_____ Strength:_____ Amount/day:_____
Name:_____ Strength:_____ Amount/day:_____
Name:_____ Strength:_____ Amount/day:_____

Allergies: ☐Y ☐N If yes, please list:_____

ADULT HISTORY: FEMALE

Date:_____

Patient Name:_____ DOB:_____

FAMILY HISTORY: (FH) ***(Limit to parents and/or siblings)***

- ☐ FH Unknown
- ☐ FH Alcoholism
- ☐ FH Anemia
- ☐ FH Anesthetic Complications
- ☐ FH Angina
- ☐ FH Anxiety
- ☐ FH Arthritis
- ☐ FH Asthma
- ☐ FH Birth Defects
- ☐ FH Bleeding Disease
- ☐ FH Breast Cancer
- ☐ FH Coronary Heart Disease – Male <55
- ☐ FH Coronary Heart Disease – Female <65
- ☐ FH Cervical Cancer
- ☐ FH Colon Cancer – Father
- ☐ FH Colon Cancer – Mother
- ☐ FH Colon Cancer
- ☐ FH Depression
- ☐ FH Diabetes
- ☐ FH Endometriosis
- ☐ FH Growth/Development
- ☐ FH Headaches
- ☐ FH Heart Disease
- ☐ FH Hypertension
- ☐ FH High Cholesterol
- ☐ FH Kidney Disease
- ☐ FH Lung Cancer
- ☐ FH Lung/Respiratory
- ☐ FH Melanoma
- ☐ FH Migraines
- ☐ FH Osteoporosis
- ☐ FH Other Cancer (Specify Below)
- ☐ FH Ovarian Cancer
- ☐ FH Premenstrual Syndrome (PMS)
- ☐ FH Psychiatric Care
- ☐ FH Seizures
- ☐ FH Severe Allergies
- ☐ FH Stroke
- ☐ FH Thyroid Problems
- ☐ FH Uterine Cancer
- ☐ FH Weight Disorder
- ☐ FH Other Medical Problems (Specify Below)

Please specify which family member for each checked: _____

_____

_____

_____

_____

SOCIAL HISTORY: (SH)

- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Single
- ☐ Widowed
- ☐ 1 Child
- ☐ 2 Children
- ☐ 3 Children
- ☐ 4+ Children
- ☐ History of Domestic Abuse
- ☐ Religion Affecting Care
- ☐ Passive Smoke Exposure
- ☐ Military Service
- ☐ Service Disability
- ☐ Other Disability

ADULT HISTORY: FEMALE

Date:_____

Patient Name:_____ DOB:_____

RISK FACTORS: Please answer the following questions in order to better assess your health risk factors.

Tobacco Use:

Currently Smoking:
☐Cigarettes Amt: _____ packs/day
☐Cigars Amt: _____ # per week
☐Smokeless/chewing Amt: _____ per day

Previous Smoker:
Year Started: _____
Year Quit: _____
Pack-Years: _____
Comments: _____

☐Never Smoked

Passive Smoke Exposure (Second Hand Smoke): ☐Yes ☐No

Drug Use: ☐None

If Yes: Substance Type: ☐Marijuana ☐Cocaine ☐Crack ☐Heroin ☐Illegal Prescription Drugs
Other: _____
Comments: _____

HIV High Risk Behavior: ☐Yes ☐No

Alcohol Use: ☐Yes ☐No

Drinks per Day: ☐<1 ☐1 ☐2 ☐3 ☐4 ☐4+

If Yes: Type _____

Caffeine Use: Drinks per Day: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5+

Exercise: Times per Week ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8+

Seat Belt Use: Percentage of Time Used: ☐100 ☐75 ☐50 ☐25 ☐0

Sun Exposure: ☐Frequently ☐Occasionally ☐Rarely