SOUTHWEST Women's HEALTH ASSOCIATES

Medical History Form

Name: _____**DOB:**__/___/___**Age:** __

Preferred name: _____

Pronouns: _____

Occupation: _____**Date:**___/___/___

Other health care providers <u>including naturopathic, chiropractic, etc.</u>:

_____

Are <u>you allergic</u> to any medications? If yes, please list name and type of reaction (ex: Penicillin, Rash)**:**

_____

_____

Are <u>you allergic</u> to any of the following?

☐ Latex ☐ Iodine ☐ Nickel ☐ Betadine

List Current medications/supplements:

_____

_____

_____

Immunizations, list date of <u>most recent</u> vaccine if know (ex: Tetanus, 1/12/20)**:**

_____

_____

Surgeries: _____

_____

Current living situation (ex: with partner and child)**:**

_____

Smoking and/or tobacco use:

☐ Never

☐ Past/Date quit: __/__/___ Age started____

☐ Packs per day: _____

Do you use E-cigarettes/vape? ☐ No ☐ Yes

Alcohol use: ☐ No ☐ Yes, how many drinks per week? _____ Type: _____

Drug use (ex: marijuana, cocaine, narcotics)**:**

☐ Never ☐ Past ☐ Present

If yes, what type of drug? _____

If yes, how often? _____

How often do you exercise/type (ex: 2-3x/week, cardio, yoga)**:**

_____

First day of last menstrual period: __/___/_____

Is your period usually:

☐ Light ☐ Moderate ☐ Heavy

Is your period regular/irregular? _____

How many days do your period last? _____

Menopausal, if yes, date of last period: ___/___/_____

How many of the following have you had?

Pregnancies ___Live births ____ Still Living ____
C-sections ____Miscarriages___ Abortions____
Still births____ Tubal Pregnancies____

Plans for future pregnancies?

☐ Yes ☐ No ☐ Undecided

Have you ever been sexually active: ☐ No ☐ Yes

If yes, how many partners within the past year? ___

Men ☐ Women ☐ Both ☐

What do you currently use for birth control?

☐ None ☐ Condoms ☐ Pills ☐ Vasectomy

☐ Other: _____

Have you ever had any sexually transmitted disease?

☐ No ☐ Yes, type? _____

Have you ever had any of the following? (Check all that apply)

☐ Abnormal Pap ☐ Fibroids ☐ Endometriosis ☐ Infertility ☐ Ovarian Cyst

Personal Medical History (please check if you have had any of the following):

☐ Anemia ☐ Asthma ☐ Stroke ☐ Thyroid Problems ☐ Depression/Anxiety ☐ Mental Illness

☐ High blood pressure ☐ Heart problems ☐ Kidney problems ☐ Kidney Stones ☐ Migraines

☐ Blood clots ☐ Osteoporosis ☐ Diabetes/Type:_____ ☐ Cancer/Type:_____

☐ Hepatitis/type: _____ ☐ Genital Herpes ☐ Pain/problems with sex ☐ Other: _____

	Date	Where	Results(normal/abnormal)
Pap Smear			
Annual Exam			
Bone Density scan			
Colonoscopy			
Mammogram			

Has anyone in **your family** ever had any of the following?

	Relative(s) (ex: children, parents, grandparents)
Osteoporosis	
Breast Cancer	
Ovarian Cancer	
High Blood Pressure	
High Cholesterol	
Stroke or Blood Clot	
Melanoma	
Diabetes	
Heart Attack under age 50	
Alcoholism	
Mental Health Problems	
Thyroid Disease	
Colon Cancer	
Other	

Do you ever feel like you are verbally or emotionally abused? ☐ Yes ☐ No

Are you in a relationship where you are being slapped, hit, or kicked? ☐ Yes ☐ No

Are you forced to have sex when you don't want to? ☐ Yes ☐ No

Do you feel you have a problem with drugs or alcohol? ☐ Yes ☐ No

Do you think you have an eating disorder like bulimia or anorexia? ☐ Yes ☐ No

Are you getting counseling right now? ☐ Yes ☐ No

Signature: _____