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a practice by John P. Schilling, MD
Schilling HEALTHCARE

Female Health History

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Patient ID: All Info ***MANDATORY*** **Today's Date:**

Patient Name: _____ DOB: _____ Current Age: _____
Address: _____ Religious Consideration: _____
_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow
Mailing Address (if different): _____ Race: _____
☐ Home: _____ Type of Insurance: _____
☐ Cell: _____ CHECK PREFERRED CONTACT NUMBER Referring Physician: _____
☐ Work: _____ Primary Physician: _____
Your Employer: _____ REASON FOR VISIT:
Employer Phone #: _____

MEDICAL & FAMILY HISTORY

Have you or any members of your family had?

	SELF	FAMILY
High Cholesterol	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Asthma	☐	☐
Tuberculosis	☐	☐
Diabetes	☐	☐
Thyroid Problems	☐	☐
Liver Disease	☐	☐
Intestinal Problems	☐	☐
Stomach, Bowel or Gall Bladder Problems	☐	☐
Kidney or Bladder Problems	☐	☐
Breast Problems	☐	☐
AIDS (HIV)	☐	☐
Hepatitis (Type ☐)	☐	☐
Anemia or Blood Disorder	☐	☐
Cancer	☐	☐
Infertility	☐	☐
Endometriosis	☐	☐
Osteoporosis	☐	☐
Lupus	☐	☐
Blood Transfusion	☐	☐
Seizures	☐	☐
Migraines	☐	☐
Depression	☐	☐
Domestic Violence	☐	☐
Abnormal Pap Smear	☐	☐
Abnormal Mammo	☐	☐
Genital warts	☐	☐
Herpes	☐	☐
Chlamydia	☐	☐
Gonorrhea	☐	☐
Sexual Problems	☐	☐
DES Exposure	☐	☐
NO KNOWN MEDICAL PROBLEMS	☐	☐

MENSTRUAL HISTORY ← PLEASE COMPLETE ALL INFO →

First Day of Last Menstrual Cycle: _____
Age at First Period: _____
# of Days Between Periods: _____
Length of Period: _____

ABNORMALITIES
☐ Excessive Bleeding
☐ Discharge
☐ Pain
☐ NONE

PRENANCY HISTORY

of Full-Term Births _____
# of Premature Births _____
# of Miscarriages _____
# of Terminations _____
# of Living Children _____

# of Births	BORN Month / Year	Baby's Sex M / F	Weight at Birth	Weeks Pregnant	Hours in Labor	Type of Delivery VAG / CS	Type of Anesthesia	Complications YES	Complications NO
1	/	*	lb oz			☐ ☐		☐	☐
2	/	*	lb oz			☐ ☐		☐	☐
3	/	*	lb oz			☐ ☐		☐	☐
4	/	*	lb oz			☐ ☐		☐	☐
5	/	*	lb oz			☐ ☐		☐	☐

CONTRACEPTIVE HISTORY ← PLEASE COMPLETE ALL INFO →

TYPE	PRESENT	IN LAST 5 YRS
☐ Oral Contraceptive Types _____	☐	☐
☐ IUD	☐	☐
☐ Diaphragm	☐	☐
☐ Norplant	☐	☐
☐ Sponge	☐	☐
☐ Spermacide	☐	☐
☐ Condoms	☐	☐
☐ Other _____	☐	☐

Sterilization ☐ Male ☐ Female

LIFESTYLE

Date of last Pap smear? _____
Has your Pap test ever been abnormal? ☐ YES ☐ NO

Are you sexually active? ☐ YES ☐ NO
Is intercourse painful to you? ☐ YES ☐ NO

Have you had a mammogram? ☐ YES ☐ NO
If so, last date of mammogram: _____

Do you exercise regularly (3+ hours a week)? ☐ YES ☐ NO
If so, ☐ Light ☐ Moderate ☐ Heavy

HOSPITALIZATIONS

List operations/serious illnesses that have required hospitalization. DO NOT LIST PREGNANCIES HERE.
☐ IF more than 6, check this box, list others below.

MONTH/YEAR	ILLNESS OR OPERATION	COMPLICATIONS YES	COMPLICATIONS NO
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

CURRENT MEDICATIONS ☐ NONE

TYPE	DOSAGE

MEDICATION ALLERY/SENSITIVITY

☐ NONE KNOWN

SUBSTANCE ABUSE

PLEASE CHECK ONLY THAT YOU USE

	TYPE	AMT/DAY
☐ Alcohol		
☐ Tobacco		
☐ Caffeine		
☐ Non-Prescribed Drugs or Street Drugs		

PATIENT SIGNATURE *Signature required at time of appointment