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# schilling HEALTHCARE

# Female Health History

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SchillingWomensCenter.com

**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