Northern Colorado Women's Wellness
COMPREHENSIVE CARE IN GYNOCOLOGY

Name _____ Today's Date _____
Reason for this visit _____

I. PAST MEDICAL HISTORY

A. Have you ever had any of the following? If yes, please describe in the space provided

	YES	DESCRIPTION
1. Headaches	_____	_____
2. Thyroid problems	_____	_____
3. High Blood Pressure	_____	_____
4. Heart Disease and/or stroke	_____	_____
5. Breast problems	_____	_____
6. Hepatitis or other liver problems	_____	_____
7. Kidney or Bladder problems	_____	_____
8. Anemia	_____	_____
9. Blood Transfusion	_____	_____
10. Diabetes	_____	_____
11. Cancer	_____	_____
12. Seizure disorders	_____	_____
13. Herpes	_____	_____
14. Condylomata (warts)	_____	_____
15. Genetic or inherited diseases	_____	_____
16. Other medical problems	_____	_____

B. How old are your parents and how is their health? If deceased, what was the cause of death and age of death?
Mother _____ Father _____

C. Have any members of your family had any of the following? If yes, please describe in the space provided.

	YES	DESCRIPTION
1. High Blood Pressure/ Heart Disease	_____	_____
2. Diabetes	_____	_____
3. Cancer	_____	_____
4. Kidney Disease	_____	_____
5. Genetic or inherited disease (s)	_____	_____
6. Other Medical Problems	_____	_____

II. PAST MEDICAL HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS AND PROVIDE SPECIFIC INFORMATION WHEN APPROPRIATE. IF A QUESTION DOES NOT APPLY, SKIP IT AND GO ON TO THE NEXT ONE.

Menstruation:

1. How old were you when you had your first period? _____
2. What was the date of your last menstrual period? _____
3. Was your last menstrual period normal? _____
4. How many days pass between the first day of each period? _____
5. How long do your periods last? _____
6. On the heaviest of day (s), how many pads and/or tampons do you use? _____

7. Do you have cramps with your periods? _____If yes:
    a. When do they start in relation to bleeding? _____
    b. How long do they last? _____
    c. Is the pain generally _____Mild _____ Moderate _____Severe
    d. Is the pain getting worse? _____
    e. How do you treat your pain? _____

8. What do you use for birth control? _____
9. Have you ever had complications with any type of birth control?
   If yes, what was it? _____
10. Have you ever had any difficulty becoming pregnant? _____
11. Are you past your menopause or have you had a hysterectomy? _____
    If yes, have you noticed vaginal bleeding since? _____

III. GYNECOLOGY

12. Do you examine your breasts? _____
13. Have you ever had a mammogram? _____
    If so, when and what were the results? _____
14. Have you ever noticed any lumps in your breast? _____
    If so, what was done? _____
15. Have you ever had any discharge from your breasts? _____
16. Have you ever had any pain or discomfort with intercourse? _____
17. Have you had problems with frequent or recurrent bladder or kidney
    Infection? _____
18. Have you had frequent and/or recurrent vaginal infections? _____
19. Have you ever had infections in your tubes and/or ovaries? _____
20. When was your last pap smear? _____
21. Have you ever had an abnormal pap smear? _____
    If yes, when and what was done? _____

IV. OTHER MEDICAL HISTORY INFORMATION

22. Are you allergic to any medications? If so, what is the name of the medication and what happened to you when you took it? _____
23. Do you take any over-the-counter or prescription medication? If so, please list the name, dosage, and how long you have taken it.

NAME	DOSAGE	DURATION TAKEN

24. Do you smoke? _____ If yes, how many cigarettes per day? _____
    How long have you smoked? _____
25. How many alcoholic beverages do you have in one week? _____
26. Do you use other recreational or social drugs? _____

27. Do you have a history of any of the following conditions?
    a) Severe, recurrent headaches _____
    b) Fainting episodes _____
    c) Recurrent shortness of breath _____
    d) Edema (swelling) of hands or ankles _____
    e) Chronic cough _____
    f) Have you ever coughed up blood? _____
    g) Have you ever noticed heavy chest pain with exercise? _____
    h) Have you noticed that your heart rate is beating irregularly or rapidly? _____
    i) Do you have lower abdominal cramps/pain not associated with your menstrual periods? _____

V. HOSPITALIZATIONS

Please list any surgeries or serious illnesses that required hospitalization (do not include pregnancies)

MONTH AND YEAR	ILLNESS/ OPERATION	HOSPITAL
1.		
2.		
3.		
4.		
5.		

VI. OBSTETRIC / PREGNANCY HISTORY

28. How many times have you been pregnant? _____
29. How many living children do you have? _____
30. Have you ever had a miscarriage? _____ If so, when? _____
31. Have you ever had an abortion? _____ If so, when? _____
32. Have you ever had a premature birth? _____
    If so, when was it and please explain the details _____
    _____

PLEASE RECORD THE DETAILS OF YOUR PREGNANCIES

Date of birth	Sex	Weight	Length of Gestation	Child's Name	Delivery type & Anesthesia	Where delivery took place

Did you have complications with any of your pregnancies? If so, what?

ARE THERE ANY POINTS IN YOUR PAST HISTORY OR OTHER QUESTIONS YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR? IF SO, PLEASE DESCRIBE: