

# Southern Utah Women's Health Center, PC

## HEALTH INFORMATION

**Name:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_  
**Today's date:** \_\_\_\_\_

**Chief complaint:** *Why are we seeing you today?*

\_\_\_\_\_

**Allergies: (Medication, Latex, food or other)**  
**\*\*Type of Reaction\*\***

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Past Medical History: (Circle all that apply)

Abnormal Pap Smear	Epilepsy/seizure disorder	Infertility problems
Anemia	Gastrointestinal disorder	Kidney stones
Anxiety	Headaches/migraines	Liver disease
Arthritis	Heart disease	Osteoporosis
Asthma	Heart murmur	Pelvic pain or cramping
Bladder disorder	Hepatitis	Pulmonary (lung) disease
Breast lump or problem	Herpes (oral cold sores)	Renal (kidney) disorder
Cancer	Herpes (genital)	STD (sexually trans. Disease)
Cholecystitis (gallbladder)	High blood pressure	Urinary stress incontinence
Clotting disorder	High cholesterol	Weight loss or gain _____ lbs.
Depression	Hypothyroid	Other
Diabetes Type I Type II	Hyperthyroid	
Details: _____ _____ _____ _____		

Recent Testing	Month/Year	Result
Bone Density scan	_____	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Colonoscopy	_____	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Mammogram	_____	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Pap smear	_____	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Have you ever had any treatment for an abnormal pap smear?		
Yes <input type="checkbox"/> No <input type="checkbox"/> Treatment _____		

### Past Surgical History

	Month/Year
Abdominal surgery _____	_____
Appendectomy _____	_____
Breast augmentation _____	_____
Breast surgery _____	_____
Cesarean Section (s) _____	_____
Tubal Ligation _____	_____
Uterine ablation _____	_____
Laparoscopy _____	_____
Reason: _____	
Hysterectomy _____	_____
Reason: _____	
Ovaries removed? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Bladder surgery _____	_____
Other pelvic surgery _____	_____
Type: _____	
Other surgery _____	_____
Type: _____	

### Menstrual History

Date when last menstrual period **begun**: \_\_\_\_\_

Age when menses started \_\_\_\_\_ years old

Number of days of flow \_\_\_\_\_ days. (ie: 3, 5)

Cycle **interval** (1<sup>st</sup> day to 1<sup>st</sup> day) \_\_\_\_\_ days. (ie: 28, 30, varies)

Flow amount: light moderate heavy

Cramping: mild moderate severe

Do you have bleeding between periods? Yes  No

Age when periods stopped (if menopausal) \_\_\_\_\_ yrs old

Taking any hormone replacement? Yes  No

### Current Method of Contraception: *please circle*

Condoms	Nothing
Oral contraceptive	Abstinence
Nuvaring	Diaphragm
Mirena IUD	Natural family planning
Paragard IUD	Withdrawal
Mini Pill	Foams/Spermicides
Depo Provera	Tubal Ligation
Ortho Patch	Vasectomy (Year) _____
Implanon	Essure (Year) _____

Are you happy with your current method? Yes  No

### Obstetrical History

	Number
Total pregnancies	_____
Full Term Deliveries (after 37 wks)	_____
PreTerm Deliveries (before 37 wks)	_____
Miscarriages	_____
Abortions	_____
Living children	_____

## Current Medications

Medications you are taking or have taken in the past 3 months (including birth control):

Do you take supplements (herbal or over the counter medications regularly)? Yes  No

Medication	Dose	How often?	Start Date	Reason taken	Prescribing doctor	Is it working for you?
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>

Do you use alcohol? Yes  No

Frequency: (circle) Rare Social Daily

Do you use tobacco: Never Former Current \_\_\_pks/day

Do you use social drugs: Yes  No

## Family Medical History: (circle all that apply)

Disease	Mothers/Fathers side	Relation	Age of Diagnosis	Comments
Birth defects				
Depression				
Diabetes				
Endometriosis				
Heart disease				
High blood pressure				
Multiple births				
Seizure disorder				
Stroke syndrome				
Other				

## Family Cancer history: (circle all that apply)

Type	Mothers/Fathers side	Relation	Age of Diagnosis	Comments
Breast				
Ovarian				
Endometrial (uterine)				
Cervical				
Colon				
Melanoma				
Thyroid				
Other				

Patient initial and date that form reviewed and updated:

Signature / Date	Signature / Date	Signature / Date	Signature / Date