FEMALE MEDICAL HISTORY

This information is confidential and will be used by your medical provider to make sure you get proper care.

☐ Yes ☐ No Are you allergic to any medications? List here:

☐ Yes ☐ No Do you take any over the counter medicines, prescription medicines, vitamins, supplements, or home remedies? List here:

☐ Yes ☐ No Do you have a usual source of primary care? If yes, who?

A. Family Medical History:

Has anyone in your family (mother, father, brother, sister) ever had:

1. ☐ Heart attack/disease
2. ☐ Stroke
3. ☐ Blood clot in legs/lungs
4. ☐ High blood pressure
5. ☐ High cholesterol
6. ☐ Diabetes
7. ☐ Alcohol or drug abuse
8. ☐ Birth defects/genetic problems
9. ☐ Mental illness
10. ☐ Maternal DES exposure
11. ☐ Cancer
12. ☐ I do not know my family medical history

B. Personal Medical History:

1. Have YOU ever had problems with any of these? Check all that apply.

A. ☐ Heart disease
B. ☐ High blood pressure
C. ☐ Stroke
D. ☐ Diabetes
E. ☐ High cholesterol
F. ☐ Tuberculosis (TB)
G. ☐ Asthma
H. ☐ Blood clot in legs/lungs
I. ☐ Bleed/bruise easily
J. ☐ Anemia
K. ☐ Sickle cell disease
L. ☐ Kidney/bladder problems
M. ☐ Seizures or epilepsy
N. ☐ Depression
O. ☐ Suicidal thoughts
P. ☐ Mental illness
Q. ☐ Severe headaches or migraines
R. ☐ Liver problems or hepatitis
S. ☐ Gall bladder disease
T. ☐ Eating disorder
U. ☐ Cancer Type: _____
V. ☐ Thyroid disease
W. ☐ Fibroids
X. ☐ Ovarian cyst/abnormality
Y. ☐ Endometriosis
Z. ☐ Infertility

2. ☐ Yes ☐ No Have you ever been hospitalized or had any surgery? If yes, when and why? _____
3. ☐ Yes ☐ No Have you ever had a transfusion or blood exposure?
4. ☐ Yes ☐ No Have you been immunized against rubella? ☐ I do not know
5. ☐ Yes ☐ No Have you been immunized against hepatitis B? ☐ I do not know
6. When was your last Pap smear? _____ ☐ I never had a Pap smear
   ☐ Yes ☐ No Have you ever had an abnormal Pap smear? If yes, when? _____
7. ☐ Yes ☐ No Have you ever had an HIV test? If yes, when was your last one? _____ Was it: ☐ Positive ☐ Negative?
8. ☐ Yes ☐ No Have you ever had a mammogram? If yes, when was your last one? _____ Was it normal? _____

C. Menstrual History:

1. Age period started: _____
2. Periods come every _____ days and last _____ days.
3. Periods are: ☐ Regular ☐ Irregular ☐ Painful ☐ Light ☐ Moderate ☐ Heavy
4. ☐ Yes ☐ No Do you have bleeding or spotting in between your periods?

D. Pregnancy History: (If you have never been pregnant, skip to next section)

1. Please list the number of the following: _____ Pregnancies _____ Live births _____ Abortions _____ Miscarriages _____ Ectopic (tubal) pregnancies
2. How long ago was your last pregnancy? _____ month(s), _____ year(s)
3. ☐ Yes ☐ No Are you currently breastfeeding?

Provider notes:

PATIENT IDENTIFICATION

7181-04 (1/10) Item #: 026293

Beverly Care
Montebello, California 90640

FEMALE HEALTH QUESTIONNAIRE
ENGLISH

ORIGINAL - Patient Chart

E. Contraception History:

1. How old were you when you first had vaginal intercourse? _____ years old ☐ I never had sex
2. How important is it for you to avoid pregnancy now? ☐ Very ☐ Somewhat ☐ Not at all
3. What birth control methods have you used in the past? ☐ None

A. ☐ Condoms/rubbers	F. ☐ IUD	J. ☐ Foam/film or jelly
B. ☐ Birth control pills	G. ☐ Implants under the skin	K. ☐ Withdrawal/pulling out
C. ☐ DepoProvera/shot	H. ☐ Diaphragm/cervical cap	L. ☐ Rhythm method
D. ☐ Patch	I. ☐ Tubal ligation/tubes tied	M. ☐ Partner has vasectomy
E. ☐ NuvaRing (vaginal ring)		

4. What birth control are you and your partner(s) currently using? _____ ☐ None
5. ☐ Yes ☐ No Are you happy with your method?
6. How often do you use condoms? ☐ Always ☐ Sometimes ☐ Never
7. ☐ Yes ☐ No Have you ever used emergency contraception (morning after pill/Plan B)?
8. ☐ Yes ☐ No ☐ Maybe Are you planning to get pregnant in the next two years?

F. Habit and Lifestyle:

If you prefer, you can talk to your health care provider about these important questions.

1. How many glasses of an alcoholic beverage do you have per week? _____ ☐ None
2. ☐ Yes ☐ No Do you smoke cigarettes? If yes, how many cigarettes per day? _____
3. ☐ Yes ☐ No Do you use street drugs? If yes, please list: _____
4. ☐ Yes ☐ No Have you ever used injected drugs?
5. ☐ Yes ☐ No Have you ever shared needles?
6. ☐ Yes ☐ No Has anyone ever told you that you have a problem with drugs or alcohol?
7. ☐ Yes ☐ No Is anyone, including your partner, threatening you, causing you to be afraid, or hurting you physically?
8. ☐ Yes ☐ No Have you ever been pressured or forced to have sex when you did not want to?
9. Have you ever had a sex partner with a history of: ☐ Injected drug use ☐ Sex with men ☐ HIV

G. Sexual History:

In the last 12 months…

1. ☐ Yes ☐ No Have you been sexually active? If no, skip to #6.
   If yes, how many sexual partners have you had?_____
2. Have you had sex with: ☐ Men ☐ Women ☐ Both?
3. Have you and/or your partner(s) had: ☐ Oral sex ☐ Anal sex ☐ Vaginal sex?
4. ☐ Yes ☐ No Have you traded sex for money or drugs?
5. Do you think that your partner has other sexual partners?
   ☐ Yes, definitely ☐ Not sure, possibly ☐ No, very unlikely
6. In the last 12 months have you or your sex partner(s) had any of the following:

A. ☐ Chlamydia	D. ☐ Trichomoniasis (Trich)	G. ☐ Bacterial vaginosis (BV)
B. ☐ Gonorrhea	E. ☐ Pelvic Inflammatory Disease	H. ☐ Syphilis
C. ☐ Genital Herpes	F. ☐ Genital warts	I. ☐ Other: _____

7. ☐ Yes ☐ No Is there anything else about your health or sexual practices that you would like to discuss with your clinician?

_____

_____

_____

_____ Patient Signature/Date

_____ Clinician Signature/Date

_____ Clinician Signature/Date Updated

_____ Clinician Signature/Date Updated

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