

# FAMILY CARE HEALTH CENTERS

## FEMALE HISTORY

**NAME** \_\_\_\_\_ **AGE** \_\_\_\_\_ **DOB** \_\_\_\_\_ **ID#** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

**Please list allergies**(medications, foods, latex, metals, other): \_\_\_\_\_

<b>Past Health History</b>	
<b>Current medications</b> (prescription, over the counter, herbal) _____	<b>Major illness/ Injuries/Disability:</b> _____
_____	_____
_____	_____
<b>Have you ever had a blood transfusion</b>	<b>Hospitalizations/Surgery</b> _____
_____ <b>Yes</b> _____ <b>No</b>	_____
<b>Have your had other blood exposure</b>	_____
_____ <b>Yes</b> _____ <b>No</b>	_____
<b>Immunizations:</b> _____ MMR (1 or 2 doses) _____ Td/TDaP _____ Hepatitis B (1 2 3 doses) _____ HPV vaccination (1 2 3 doses) _____ Other _____	

**Health Habits:**  
 How can we help you with questions about your diet/nutrition? \_\_\_\_\_  
 Do you have concerns about your weight?  Yes  No Do you take folic acid daily?  Yes  No Do you use seat belts?  Yes  No  
 How many times a week do you exercise? \_\_\_\_\_ Do you have concerns about your sleeping habits?  Yes  No

**Personal Risk:**  
 Do you use tobacco?  Yes  No Type \_\_\_\_\_ amount per day \_\_\_\_\_ Do you use cigarette substitutes?  Yes  No Type? \_\_\_\_\_  
 Do you drink alcohol?  Yes  No How much, how often? \_\_\_\_\_ Do you now or have you ever used IV Drugs?  Yes  No  
 Do you now or have you used street drugs or prescriptions for recreational use?  Yes  No Type \_\_\_\_\_  
 Have you ever sought treatment for substance abuse?  Yes  No

**Family Health History:**  
 Are you adopted?  Yes **(If yes and you do not know your family history, you may skip this section)**  No (please continue with this section)  
 Have any of your blood relatives had the following conditions? Please say who they are. (Include your mother, father, brothers, and sisters)  
 \_\_\_\_\_ Diabetes \_\_\_\_\_ High cholesterol / triglycerides \_\_\_\_\_ Sickle Cell Anemia \_\_\_\_\_  
 \_\_\_\_\_ Cancer \_\_\_\_\_ (type) \_\_\_\_\_ High blood pressure \_\_\_\_\_ Stroke \_\_\_\_\_  
 \_\_\_\_\_ Phlebitis or clots in the veins \_\_\_\_\_ at what age \_\_\_\_\_ Heart disease or heart attack \_\_\_\_\_ at what age \_\_\_\_\_  
 If you were born before 1971, did your mother receive a hormone called Diethylstilbestrol (DES) while pregnant with you?  Do not know/not sure  
 Yes  No

**Sexual History:**  
 Have you ever had sex?  Yes  No  
**(If no, you may skip this section)**  
 What types of sex have you had?  Oral  Anal  Vaginal  
 How old were you when you first had intercourse? \_\_\_\_\_  
 Are you experiencing any pain, discomfort or bleeding with or after intercourse?  Yes  No  
 Have you had a new sexual partner or more than one sexual partner in the last year?  Yes  No  
 How many sexual partners in your lifetime? \_\_\_\_\_  
 Were/Are your sexual partners: \_\_\_\_\_ men \_\_\_\_\_ women \_\_\_\_\_ both  
 \_\_\_\_\_ IV drug users \_\_\_\_\_ partner with multiple partners or at risk for HIV/STD \_\_\_\_\_ recently treated for STD  
 Please circle any of the following that you have been treated for:  
 Chlamydia Gonorrhea Syphilis Hepatitis B  
 Treatment date(s) \_\_\_\_\_  
 Was your partner also treated?  Yes  No

**Pregnancy History:**  
 Do you plan to have children?  Yes  No  
 If yes, when? \_\_\_\_\_  
 Would you like information that could help you to have a healthy pregnancy when the time is right for you?  Yes  No  
 If you do not plan to have children now or ever, how do you plan to prevent pregnancy? \_\_\_\_\_  
 Have you ever been pregnant?  Yes  No **(If no, skip this section)**  
 Age at first pregnancy: \_\_\_\_\_  
 Have you been pregnant within the past year?  Yes  No  
 Number of times pregnant: \_\_\_\_\_  
 Number of live births: \_\_\_\_\_  
 Number of living children: \_\_\_\_\_ Ages: \_\_\_\_\_  
 Number of C-sections: \_\_\_\_\_  
 Number of miscarriages: \_\_\_\_\_  
 Number of abortions: \_\_\_\_\_  
 Number of ectopic/tubal pregnancies: \_\_\_\_\_  
 Describe any problems you had during pregnancy (high blood pressure; depression; high blood sugars) \_\_\_\_\_  
 Are you breastfeeding now?  Yes  No  
 Do you think you may be pregnant now?  Yes  No

**Menstrual:**  
 How old were you when your periods began? \_\_\_\_\_  
 When did your last period start? (date) \_\_\_\_\_  
 Was this period normal?  Yes  No  
 Is your period late?  Yes  No  
 How many days does your period last? \_\_\_\_\_ (**≥8 days**)  
 How many days from the start of one period until the start of your next period? \_\_\_\_\_ (**≤20 or ≥36 days**)  
 How many pads/tampons per day do you use? \_\_\_\_\_  
 Do you bleed between periods?  Yes  No  
 Have you noticed a change in your periods?  Yes  No  
 Do you have pain with periods or in between?  Yes  No  
 Do you have irritability, weight gain, backache, or mood changes before or during your period?  Yes  No  
**Do you have clots with your periods**  Yes  No

**Contraceptives:**  
 Check all of the birth control methods you have used:  
 Abstinence (not having sex)  Pill  
 Sterilization  Foam, suppository, gel, film  
 Withdrawal  Condoms  
 Diaphragm  Depo Provera  
 Norplant / Implanon  IUD  
 Sponge  Birth Control Patch  
 Vaginal ring  Natural Family Planning  
 Other \_\_\_\_\_  
 What is the most recent birth control method you have used? \_\_\_\_\_  
 Are you using birth control now?  Yes  No  
 If yes, how long have you been using it? \_\_\_\_\_  
 If no, when did you stop using it? Why did you stop using it? \_\_\_\_\_  
 Have you had problems with any birth control methods?  Yes  No  
 If yes, describe \_\_\_\_\_  
 Do you want a birth control method today  Yes  No  
 What method do you think you would like to have? \_\_\_\_\_  
 Does your partner ever sabotage your birth control?  Yes  No  
 Does your partner pressure you to get pregnant if you don't want to?  Yes  No

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<p><b>SOCIAL INFORMATION:</b>          Have you ever been hit, slapped, kicked or verbally abused? _____ Yes ___ No          Have you ever been forced to have sex or perform sexual acts when you didn't want to? _____ Yes ___ No          Have you ever been sexually molested? _____ Yes ___ No          Do you have someone to talk to when you are sad or feel bad? _____ Yes ___ No          Are you currently in an abusive relationship? _____ Yes ___ No          Are you afraid of your partner or anyone else? (parent, relative, neighbor, etc)? _____ Yes ___ No          Are you safe at home? _____ Yes ___ No</p>	<p><b>PAP HISTORY:</b>          Have you ever had a PAP smear? _____ Yes ___ No  <b>(if no, you may skip this section)</b>          When was your last Pap smear? _____          Where was your last pap smear done? _____          Have you <b>ever</b> had an abnormal Pap smear? _____ Yes ___ No          If yes, when? _____ What was the treatment? _____</p>
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<b>REVIEW OF SYSTEMS</b>											
<b>No = no problems with this now</b>				<b>Yes = having problems now</b>				<b>Past = have had this problem in the past</b>			
NO	YES	PAST	<b>GENERAL</b>	NO	YES	PAST	<b>RESPIRATORY</b>	NO	YES	PAST	<b>GENITOURINARY</b>
			rapid weight gain or weight loss				asthma				
			recent weight loss (unintended)				tuberculosis (TB)				
			frequent cold, flu, etc.				chronic cough				
			chronic fatigue >6 months								
			cancer: _____								
			genetic condition: _____								
			HIV/AIDS								
NO	YES	PAST	<b>CARDIOVASCULAR</b>	NO	YES	PAST	<b>HEMATOLOGIC</b>	NO	YES	PAST	<b>ENDOCRINE</b>
			heart disease/ heart murmur				anemia				diabetes/diabetes in pregnancy
			high blood cholesterol				blood clotting disorder				thyroid problems
			varicose veins				sickle cell disease				
			high blood pressure								
			blood clot in lungs or veins								
			stroke								
NO	YES	PAST	<b>NEUROLOGIC</b>	NO	YES	PAST	<b>HEMATOLOGIC</b>	NO	YES	PAST	<b>ENDOCRINE</b>
			migraines (diagnosed)				anemia				diabetes/diabetes in pregnancy
			sensory difficulties (numbness, smell, taste)				blood clotting disorder				thyroid problems
			seizures/epilepsy/dizziness/fainting				sickle cell disease				
NO	YES	PAST	<b>GASTROINTESTINAL</b>	NO	YES	PAST	<b>HEMATOLOGIC</b>	NO	YES	PAST	<b>EYES</b>
			stomach/bowel problems (constipation, diarrhea, blood in stool)								eye problems (NOT GLASSES OR CONTACTS)
			liver disease/jaundice/mono								
			hepatitis								
			gall bladder disease								
NO	YES	PAST	<b>SKIN</b>	NO	YES	PAST	<b>HEMATOLOGIC</b>	NO	YES	PAST	<b>EARS, NOSE, THROAT, MOUTH</b>
			acne								frequent nosebleeds
			chronic rash or itching								hearing problems
			breast: discharge, lump, surgery								teeth/gum problems
			other skin problem: _____								frequent sore throat
NO	YES	PAST	<b>MUSCULOSKELETAL</b>	NO	YES	PAST	<b>HEMATOLOGIC</b>	NO	YES	PAST	<b>PSYCHOLOGIC</b>
			fractures/broken bones								anxiety
NO	YES	PAST	<b>AUTOIMMUNE</b>	NO	YES	PAST	<b>HEMATOLOGIC</b>	NO	YES	PAST	<b>PSYCHOLOGIC</b>
			Lupus								depression
			rheumatoid arthritis								severe mood swings
			fibromyalgia								thoughts of suicide
											any traumatic, painful or emotional event

Is there anything else we should know about you? \_\_\_\_\_

I have received information on the benefits and risks, effectiveness, potential side effects, complications, discontinuation issues and danger signs of the contraceptive method chose. I have been counseled, provided with appropriate informational materials and I understand the content.

Client Signature \_\_\_\_\_

Date \_\_\_\_\_

Reviewed by Health Care Provider \_\_\_\_\_

Date \_\_\_\_\_