



Selah Women's Health

HEALTH HISTORY INTAKE FORM

NAME (Last, First):		Primary Care Provider:				
Preferred Pharmacy:		Other Providers:				
How did you hear about us?		Referring Provider:				
PERSONAL MEDICAL HISTORY						
OB/GYN Surgical History: OR <input type="checkbox"/> None YEAR <input type="checkbox"/> D&C _____ <input type="checkbox"/> Ectopic pregnancy _____ <input type="checkbox"/> Hysteroscopy _____ <input type="checkbox"/> Hysterectomy (total, partial, vaginal) _____ <input type="checkbox"/> Infertility surgery _____ <input type="checkbox"/> Tubal ligation _____ <input type="checkbox"/> Laparoscopy _____ <input type="checkbox"/> Myomectomy _____	YEAR <input type="checkbox"/> Ovarian cyst removal _____ <input type="checkbox"/> Removal of ovary(ies) _____ <input type="checkbox"/> LEEP or cervical cone _____ <input type="checkbox"/> Bladder sling _____ <input type="checkbox"/> Vaginal repair (prolapse) _____ <input type="checkbox"/> Cesarean section _____ <input type="checkbox"/> Cerclage _____ <input type="checkbox"/> Other (specify): _____	Medical History: <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Breast cancer <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Eating disorder <input type="checkbox"/> Epilepsy	<input type="checkbox"/> Headaches <input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Mental health disorder, other <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Thyroid disease			
Other Surgical History: YEAR <input type="checkbox"/> Appendectomy _____ <input type="checkbox"/> Breast surgery _____ <input type="checkbox"/> Gallbladder removal _____ <input type="checkbox"/> Heart surgery _____	Other (specify): _____	List other medical problems: (or explain above)				
Vaccines: YEAR <input type="checkbox"/> Tdap (tetanus) _____ <input type="checkbox"/> Flu _____ <input type="checkbox"/> Hepatitis B _____	YEAR <input type="checkbox"/> Gardasil _____ <input type="checkbox"/> Pneumovax _____ <input type="checkbox"/> Zoster _____ <input type="checkbox"/> Other (Specify): _____	List any Allergies: Blood type (circle one if known): A B AB O+ O-				
OBSTETRIC HISTORY						
Total # of pregnancies:		# Full-term pregnancies (>37 wks):		# Ectopics:	# Abortions:	# Miscarriages:
Total # living children:		# Premature births:		# Multiple births:		
Pregnancy Details (Please list in order of oldest to youngest. Note complications such as GDM, preeclampsia, bleeding, vaginal tears, postpartum hemorrhage)						
DATE	GESTATIONAL AGE AT BIRTH (weeks)	LENGTH OF LABOR (hours)	DELIVERY ROUTE (Vaginal, C-Section, Vacuum, Forceps, D&C)	WEIGHT (Pounds, ounces)	GENDER (M/F)	COMPLICATIONS
Comments:						
Gynecologic History:						
Date of last menstrual period:		Age at first period:		<input type="checkbox"/> Regular periods, every ____ days <input type="checkbox"/> Irregular periods, every ____ to ____ days		
Does bleeding or spotting occur between periods? <input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> Duration of bleeding: ____ days		
Does bleeding or spotting occur after intercourse? <input type="checkbox"/> YES <input type="checkbox"/> NO				Is pain associated with periods? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> OCCASIONALLY		
Current birth control method:				Other symptoms with period:		

Infection History: OR <input type="checkbox"/> None YEAR <input type="checkbox"/> Bacterial vaginosis _____ <input type="checkbox"/> Chlamydia _____ <input type="checkbox"/> Genital warts _____ <input type="checkbox"/> Gonorrhea _____ <input type="checkbox"/> Herpes, genital _____		YEAR <input type="checkbox"/> PID _____ <input type="checkbox"/> Trichomonas _____ <input type="checkbox"/> Syphilis _____ <input type="checkbox"/> PID _____ <input type="checkbox"/> Other (specify): _____	PAP History: Date of last pap: _____ History of abnormal pap? <input type="checkbox"/> YES <input type="checkbox"/> NO _____ Prior colposcopy? <input type="checkbox"/> YES <input type="checkbox"/> NO _____
Mammogram: Date of last mammogram: _____ Result: _____ Where: _____		Colonoscopy: Date of last colonoscopy: _____ Result: _____ Where: _____	
Menopause History: OR <input type="checkbox"/> N/A Age of onset: _____ Any symptoms from menopause currently: Taking hormone replacement therapy: <input type="checkbox"/> YES <input type="checkbox"/> NO List any hormones taken: <input type="checkbox"/> YES <input type="checkbox"/> NO			
SOCIAL HISTORY			
Ethnicity:		Primary Language:	
Employment:		Religious preference:	
Who lives with you currently?		Marital Status: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> LONG-TERM RELATIONSHIP <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED Partner's Name: _____	
Emergency Contact: _____ Relationship: _____ Phone: _____		Smoking Status: <input type="checkbox"/> NEVER SMOKER <input type="checkbox"/> FORMER SMOKER (For _____ years) Quit _____ (date) <input type="checkbox"/> CURRENT SMOKER How many packs a day? _____ How many years? _____	
Do you exercise? <input type="checkbox"/> YES <input type="checkbox"/> NO How often? _____ times a week for _____ minutes each time. What do you do?		Do you drink any alcohol? <input type="checkbox"/> YES <input type="checkbox"/> NO Number of drinks a week: _____	
Recreational Drugs: (specify current or history)			
		<input type="checkbox"/> Marijuana <input type="checkbox"/> CURRENTLY <input type="checkbox"/> IN THE PAST Last Use: _____	
		<input type="checkbox"/> Methamphetamine <input type="checkbox"/> CURRENTLY <input type="checkbox"/> IN THE PAST Last Use: _____	
		<input type="checkbox"/> Cocaine <input type="checkbox"/> CURRENTLY <input type="checkbox"/> IN THE PAST Last Use: _____	
		<input type="checkbox"/> Heroin <input type="checkbox"/> CURRENTLY <input type="checkbox"/> IN THE PAST Last Use: _____	
		<input type="checkbox"/> Prescription Pain Medications <input type="checkbox"/> CURRENTLY <input type="checkbox"/> IN THE PAST Last Use: _____	
		Other (specify): _____ <input type="checkbox"/> CURRENTLY <input type="checkbox"/> IN THE PAST Last Use: _____ _____ <input type="checkbox"/> CURRENTLY <input type="checkbox"/> IN THE PAST Last Use: _____	
FAMILY HISTORY (list any medical problems)			
Mother and Mother's extended family:		Father and Father's extended family:	
Siblings:		Children:	
MEDICATIONS			
Please list all medications you are currently taking, with doses:			