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 ☐ None **YEAR**

- ☐ D&C _____
- ☐ Ectopic pregnancy _____
- ☐ Hysteroscopy _____
- ☐ Hysterectomy (total, partial, vaginal) _____
- ☐ Infertility surgery _____
- ☐ Tubal ligation _____
- ☐ Laparoscopy _____
- ☐ Myomectomy _____

YEAR

- ☐ Ovarian cyst removal _____
- ☐ Removal of ovary(ies) _____
- ☐ LEEP or cervical cone _____
- ☐ Bladder sling _____
- ☐ Vaginal repair (prolapse) _____
- ☐ Cesarean section _____
- ☐ Cerclage _____
- ☐ Other (specify):

Medical History:

- ☐ Abnormal pap smear
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Breast cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Headaches
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Incontinence
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mental health disorder, other
- ☐ Sleep apnea
- ☐ Thyroid disease

Other Surgical History: **YEAR**

- ☐ Appendectomy _____
- ☐ Breast surgery _____
- ☐ Gallbladder removal _____
- ☐ Heart surgery _____

Other (specify):

List other medical problems: (or explain above)

Vaccines: **YEAR**

- ☐ Tdap (tetanus) _____
- ☐ Flu _____
- ☐ Hepatitis B _____

YEAR

- ☐ Gardasil _____
- ☐ Pneumovax _____
- ☐ Zoster _____
- ☐ 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:	☐ Regular periods, every _____ days ☐ Irregular periods, every _____ to _____ days
Does bleeding or spotting occur between periods? ☐ YES ☐ NO		☐ Duration of bleeding: _____ days
Does bleeding or spotting occur after intercourse? ☐ YES ☐ NO		Is pain associated with periods? ☐ YES ☐ NO ☐ OCCASIONALLY
Current **birth control** method:		Other symptoms with period:

Infection History:

OR ☐ None **YEAR**

☐ Bacterial vaginosis _____
☐ Chlamydia _____
☐ Genital warts _____
☐ Gonorrhea _____
☐ Herpes, genital _____

YEAR

☐ PID _____
☐ Trichomonas _____
☐ Syphilis _____
☐ PID _____
☐ Other (specify):

PAP History:

Date of last pap: _____

History of abnormal pap? ☐ YES ☐ NO

_____

Prior colposcopy? ☐ YES ☐ NO

_____

Mammogram:

Date of last mammogram: _____ Result: _____

Where: _____

Colonoscopy:

Date of last colonoscopy: _____ Result: _____

Where: _____

Menopause History: OR ☐ N/A Age of onset: _____

Any symptoms from menopause currently:

Taking hormone replacement therapy: ☐ YES ☐ NO

List any hormones taken: ☐ YES ☐ NO

SOCIAL HISTORY

Ethnicity:

Primary Language:

Religious preference:

Employment:

Marital Status: ☐ SINGLE ☐ MARRIED ☐ LONG-TERM RELATIONSHIP ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

Partner's Name:

Who lives with you currently?

Emergency Contact: _____

Relationship: _____

Phone: _____

Smoking Status:

☐ NEVER SMOKER

☐ FORMER SMOKER (For _____ years) Quit _____ (date)

☐ CURRENT SMOKER

How many packs a day? _____

How many years? _____

Do you exercise? ☐ YES ☐ NO

How often? _____ times a week for _____ minutes each time.

What do you do?

Do you drink any alcohol?

☐ YES ☐ NO

Number of drinks a week: _____

Recreational Drugs: (specify current or history)

☐ Marijuana	☐ CURRENTLY	☐ IN THE PAST	Last Use: _____
☐ Methamphetamine	☐ CURRENTLY	☐ IN THE PAST	Last Use: _____
☐ Cocaine	☐ CURRENTLY	☐ IN THE PAST	Last Use: _____
☐ Heroin	☐ CURRENTLY	☐ IN THE PAST	Last Use: _____
☐ Prescription Pain Medications	☐ CURRENTLY	☐ IN THE PAST	Last Use: _____
Other (specify): _____	☐ CURRENTLY	☐ IN THE PAST	Last Use: _____
_____	☐ CURRENTLY	☐ 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: