Mt Hood Women's Health, P.C. Initial Health History

Name: _____ **DOB:**_____ **Date:**_____

Reason for today's visit: _____

Gynecologic/Obstetric History

Current Birth Control: □ Tubal □ Vasectomy □ Depo Injection □ IUD □ Pill □ Other:_____

Past birth control methods: _____

First day of last menstrual period: ____/____/____
□ No period because of birth control method
How many days does your period last? ____
Bleeding between periods? □ Yes □ No
Bleeding after menopause? □ Yes □ No
Heavy or painful periods? □ Yes □ No (circle which)
Number of Pregnancies (include current) ____
Vaginal Deliveries ____ C-Sections ____
Miscarriages ____ Abortions ____
Do you perform self breast exams? □ Yes □ No
Do you exercise? □ Yes □ No Type?_____

Are you sexually active? □ Yes □ No
With □ Man □ Woman □ Both
New sexual partner in the past year? □ Yes □ No
How long have you been with this partner? _____
History of sexual or physical abuse? □ Yes □ No
Current sexual or physical abuse? □ Yes □ No
Date of last pap smear: ____/____/____
History of abnormal pap smear? □ Yes □ No
History of sexually transmitted disease? □ Yes □ No
Type:_____
Date of last mammogram: ____/____/____
History of abnormal mammogram? □ Yes □ No

Do you have any of the following symptoms? **(Please circle which problem)**

□ Abdominal/Pelvic Pain
□ Constipation/Diarrhea/Blood in Stool
□ Urine Leakage
□ Vaginal Itching, Irritation, or Discharge
□ Breast Lumps or Discharge
□ Sexual Concerns
□ Unexplained Weight Loss/Gain
□ Frequent Headaches
□ Depression, Anxiety, Irritability, Trouble Sleeping
□ Hot Flashes/Vaginal Dryness
□ Painful Intercourse
□ Abnormal Bleeding
□ Other: _____

Social History and Habits

Are you: □ Single □ Married □ Divorced/Separated □ Widowed □ Partnered
Do you work outside the home? □ No □ Yes, Occupation: _____
Do you have children? □ No □ Yes, Ages: _____
Tobacco Use? □ No □ Yes □ Past # cigarettes/day ____ Age began: ____ Age quit: _____
Alcohol Use? □ No □ Yes, Amount per day/week: _____
Drug Use? □ No □ Yes, Type: _____ Amount per day/week: _____

Current Medications: Prescribed/Over the Counter/Supplements/Herbs

Medication/Dose	Medication/Dose	Medication/Dose
_____	_____	_____
_____	_____	_____

List allergies to medications and your reaction:

Medication/Reaction	Medication/Reaction
_____	_____
_____	_____

~Continue on Reverse~

List any Surgeries you have had, please include type of surgery and date: _____

_____

_____

Screening/Health Maintenance

Health tests:	Date:	Result:	**Immunizations:**	Date:
Bone Density Exam			TDaP (Tetanus)	
Cholesterol Test			Hepatitis A	
Diabetes Test			Hepatitis B	
Thyroid Test			Gardasil	
Mammogram			Measles/Mumps/Rubella	
Colon Cancer Screening			Flu shot	
			Pneumonia	
			Shingles	

If deemed medically necessary and appropriate, do you consent to receive blood or blood products?

□ Yes □ No, I would like participate in the Legacy Bloodless Surgery Program

Past Medical and Family History

Please provide dates and details for your own medical history. For family, mark if yes.

	Self	**Mother**	**Father**	**Brother**	**Sister**	**MGM**	**MGF**	**PGM**	**PGF**	**Other (specify)**
Alcohol/Drug abuse										
Arthritis										
Bleeding/blood disorder										
Cancer **Type:**										
Depression										
Diabetes										
Gastrointestinal problems										
Genetic diseases/birth defects										
Heart problems										
High cholesterol										
Hypertension										
Kidney problems										
Mental illness **Type:**										
Musculoskeletal problems										
Obesity										
Osteoporosis										
Stroke										
Thyroid disease										