



W o m e n M a k i n g H e a l t h C a r e A c c e s s i b l e

MEDICAL RECORD

Today's Date _____

Legal Name _____ Birth date _____ Age _____

Preferred Name _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Phone #1 _____ (c / h / w) Phone #2 _____ (c / h / w)

Occupation _____ Employer _____

Birthplace _____ Primary Language _____ SS# _____

Your medical record is CONFIDENTIAL. Please answer the following questions briefly. If there are questions you wish to omit, feel free to do so. This document is for our use only. It will not be released with your medical records.

**HAVE YOU EVER HAD OR ARE YOU HAVING PROBLEMS WITH ANY OF THE FOLLOWING?
IF YES, PLEASE NOTE IF THE PROBLEM IS CURRENT OR PAST**

- | | |
|--|---|
| _____ 1. Skin Problems | _____ 13. Bladder or Kidney Infections |
| _____ 2. Eyes, Ears, Nose, Throat Conditions | _____ 14. Urinary Pain or Burning |
| _____ 3. Asthma | _____ 15. Diabetes |
| _____ 4. Tuberculosis | _____ 16. Thyroid Problems |
| _____ 5. Lung Problems | _____ 17. Anemia or other Blood Disorder |
| _____ 6. Heart Disease | _____ 18. Hepatitis or Liver Disease |
| _____ 7. Rheumatic Fever | _____ 19. Cancer (specific organ) |
| _____ 8. Chest Pain | _____ 20. Joint or Muscle Pain |
| _____ 9. High Blood Pressure | _____ 21. Severe Headaches or Migraines |
| _____ 10. Blood Clots or Vein Problems | _____ 22. Fainting or Dizzy Spells |
| _____ 11. Breast Problems (lumps, soreness, discharge, cancer) | _____ 23. Immune System Disorders (HIV, Lupus, CMV, Multiple Sclerosis) |
| _____ 12. Gastrointestinal Pain or Problems | _____ 24. Other: _____ |

EXPLAIN (DATES OF PROBLEMS AND TREATMENT): _____

ALLERGIES: Do you have any allergies to any medications or substances (penicillin, sulfa, aspirin, iodine, gluten, doxycycline, latex, etc.)?

CURRENT MEDICATIONS (INCLUDING HORMONES): Please list: _____

CURRENT SUPPLEMENTS/VITAMINS/HERBS: Please list: _____

HOSPITALIZATIONS/ SURGERIES: List dates, condition, treatment: _____

DISABILITIES: Please list _____

Have you had a cholesterol test in the past 5 years? _____ If so, when? _____

Have you had any of the following vaccines? (Check if yes) _____ Hepatitis B _____ HPV

FAMILY HISTORY: Have any members of your family had (write in relationship and age of onset):

_____ Heart Disease _____ Breast Cancer _____

_____ Stroke _____ Other Cancer (what type?) _____

_____ High Blood Pressure _____

_____ High Cholesterol _____ Diabetes _____

_____ Blood clots _____ TB _____

_____ Other _____

(_____ Family health history unknown _____ Father's history unknown _____ Mother's history unknown)

EMOTIONAL HEALTH:

Do you have any unusual stress in your life at this time?

Do you have a history of emotional health problems? _____

Have you recently been in a situation that feels unsafe or harmful to you? _____

Have you in the past or are you currently experiencing emotional, sexual or physical abuse or violence?

Are you interested in counseling or other well-being referrals? _____

HABITS: Smoke tobacco _____/ day Alcohol _____ Other drug use _____

Coffee/tea/soda _____/ day Sleep _____ hrs./night

Describe your eating habits. _____

Do you have or have you had an eating disorder? _____

Is food or eating a source of anxiety for you? _____

Exercise (type and amount): _____

GENDER:

How do you identify? (check one or more)

_____ Woman _____ Trans _____ Intersex _____ Man _____ Gender queer (or describe your

gender) _____ Preferred pronoun: _____

SEXUAL ACTIVITY:

Are you currently sexually active with a partner/partners? _____

If no, have you ever had sexual contact with a partner in the past? _____

If yes, is/are your current partner/partners: _____ Female _____ Male _____ Trans _____ Intersex

If having vaginal sex with males, do you use contraception? _____

Do you have any sexual concerns or problems? _____

Do you have any questions or concerns regarding sexual pleasure or orgasm? _____

Do you use any methods to protect yourself from sexually transmitted infections? _____

Have you ever had a screening for sexually transmitted infections? _____

WHAT (IF ANY) CONTRACEPTIVE METHODS HAVE YOU USED?

WHEN/HOW LONG?

PROBLEMS?

GYNECOLOGICAL:

Age menstrual periods began _____

Menopause at age _____

First day of last menstrual period _____

Are periods regular? _____

How many days from the first day of one period to the first day of the next period? _____

How many days do you bleed? _____

Do you ever bleed between periods? _____

During your period do you have excessive bleeding, pain, cramping, or vomiting? _____

Has there been any recent change in your menstrual period? _____

Do you have pre-menstrual symptoms or problems? Describe: _____

Number of pregnancies _____ Live births (dates) _____

Miscarriages/stillbirths (dates) _____ Abortions (dates) _____

Any complications related to pregnancy? _____

Date of last PAP smear _____

Result _____

Date of last Mammogram _____

Result _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? CHECK IF YES.

_____ Abnormal Pap Smear

_____ Ovarian Cysts

_____ Colposcopy

_____ Vaginal Infections (Yeast/Bacterial)

_____ Cryosurgery

_____ Sexually Transmitted Diseases or Infections (Chlamydia, Gonorrhea, Herpes, Genital Warts, Syphilis, Hepatitis, Trichomonas)

_____ Cone Biopsy, LEEP or Laser Surgery

_____ Uterine Fibroids

_____ Pelvic Inflammatory Disease

_____ Endometriosis

EXPLAIN (GIVE DATES OF PROBLEMS AND TREATMENT): _____

IS THERE ANYTHING ELSE YOU WANT TO TELL US? _____
