



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 History Record

Today's Date _____

Name _____ Birthdate _____ Age _____

Address _____ 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 any questions you wish to omit, feel free to do so. This document is for our use only, and would never be released with your medical records.

HAVE YOU EVER HAD OR ARE YOU HAVING PROBLEMS WITH ANY OF THE FOLLOWING? CHECK IF YES.

- | | |
|--|---|
| _____ 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 |
| _____ 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 (GIVE DATES OF PROBLEMS AND TREATMENT): _____

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

CURRENT MEDICATIONS: Please list: _____

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

DISABILITIES: Please list _____

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

_____ Diabetes _____ TB _____

_____ Heart Attack _____ Cancer (what type?) _____

_____ Stroke _____

_____ High Blood Pressure _____ Other _____

EMOTIONAL HEALTH:

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

Do you have a history of emotional health problems? _____

Are you facing a situation that feels unsafe or harmful to you? _____

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

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

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

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

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:

Do you identify as: (check one or more)

_____ Female _____ Transgender _____ Intersex _____ Male _____ Gender queer

(or describe your gender) _____

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

_____ Transgender _____ Intersex

If sexually active with men, 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 practice safer sex? _____

Do you have questions or concerns about safer sex practices? _____

WHAT (IF ANY) BIRTH CONTROL
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 your periods usually last for? _____

Do you ever bleed in 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 _____ Results _____

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

_____ Abnormal Pap Smear

_____ Endometriosis

_____ Colposcopy

_____ Ovarian Cysts

_____ Cryosurgery

_____ Vaginal Infections (Yeast/Bacterial)

_____ Cone Biopsy

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

_____ LEEP or Laser Surgery

_____ Uterine Fibroids

_____ Pelvic Inflammatory Disease

EXPLAIN (GIVE DATES OF PROBLEMS AND TREATMENT): _____

IS THERE ANYTHING ELSE YOU WANT TO TELL US? _____
