



Northside
WOMEN'S HEALTH

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Name: _____ Date: _____ Birthdate: _____

Allergies to Medications: _____

Medications, Vitamins, and Supplements: _____

Surgeries: _____

Your Medical History:

- High Blood Pressure _____
- Diabetes _____
- Heart Disease _____
- Stroke _____
- Blood clots in leg or lung _____
- Bleeding disorder _____
- Endometriosis _____
- Asthma _____
- Seizures _____
- Lupus or other joint disease _____
- Depression _____
- Anxiety _____
- Bipolar illness _____
- Anorexia or Bulimia _____
- Irritable bowel syndrome _____
- Chron's disease or Ulcerative Colitis _____
- Breast Cancer _____
- Cancer of the Uterus, Cervix, or Ovary _____
- Colon Cancer _____
- Thyroid disease _____
- Osteoporosis _____
- Other: _____

Family Medical History/affected relative

- High Blood Pressure _____
- Diabetes _____
- Heart Disease _____
- Stroke _____
- Blood Clots in Leg or Lung _____
- Bleeding Disorder _____
- Endometriosis _____
- Asthma _____
- Seizures _____
- Lupus _____
- Depression _____
- Anxiety _____
- Bipolar Illness _____
- Anorexia _____
- IBS _____
- Chrons or Ulcerative Colitis _____
- Breast Cancer _____
- Cancer of the Uterus, Cervix, Ovary _____
- Colon Cancer _____
- Thyroid Disease _____
- Osteoporosis _____
- Other: _____

Gynecologic History:

Age of first Menses: _____ Frequency of Menses: every _____ days Do you have: Cramping/
 Age of Last Menses: _____ Duration of Flow: _____ days Clotting/Heavy Flow

Have you ever had an abnormal pap smear? Yes/no _____

Have you ever had : Colposcopy / Cryotherapy / LEEP / Cone Biopsy / Laser Ablation _____

Have you ever had: Gonorrhea / Chlamydia / Herpes (oral or genital) / genital warts _____

What do you use for contraception? _____

Have you had any of these Gyn surgeries? Hysterectomy / Removal of Ovaries / Laparoscopy _____

If you have had a hysterectomy, why did you have the surgery? _____

Obstetrical History:

Total Number of Pregnancies _____ Total number of Miscarriages _____ Total Number of Living Children _____

Year: Sex: Weight: Type of Delivery: Delivering Dr: Complications:

Social History:

Single / Widowed / Married / Divorced
Heterosexual / Homosexual / Bisexual
Occupation: _____
Exercise Routine: _____
Diet: _____

Tobacco Use (how many cigarettes/day?) _____ How many years? _____
Alcohol Use (how many drinks/day?) _____
Drug Use: _____