ARIZONA COMMUNITY PHYSICIANS

J. Manuel Herrera, M.D.
Women's Health History

Date _____

ID# _____

Name _____ **PHARMACY:** _____

Date of Birth _____ _____

Marital Status _____ **CROSS STREETS:** _____

GYNECOLOGICAL HEALTH

GENERAL

Date of last Pap smear _____

Have you ever had an abnormal Pap smear? ☐ Yes ☐ No

Date of last mammogram _____

☐ Normal Results ☐ Abnormal Results

Do you do breast self-exams every month? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

MENSTRUAL HISTORY

First day of last Menstrual period _____

Age you were when period started _____

Have you gone through menopause? ☐ Yes ☐ No

Are you periods regular? ☐ Yes ☐ No ☐ Varies

Cycle:_____ days (from start to start)

How many days do your periods last? _____

Flow: ☐ Light ☐ Medium ☐ Heavy

Do you have bleeding or spotting between your periods?
☐ Yes ☐ No

Describe the intensity of pain you experience with your periods:
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Incapacitating

PREGNANCY HISTORY

Have you ever been pregnant? ☐ Yes ☐ No

If yes, how many times have you been pregnant? _____

How many children do you have? _____

Do you have infertility problems? ☐ Yes ☐ No

If yes, please describe _____

_____

_____

_____

BIRTH CONTROL

What contraception method do you currently use?

_____

_____

_____

_____

ALLERGIES

SUBSTANCE/NAME	REACTION

GENERAL HEALTH CONDITIONS

Check ☑ symptoms you currently have or have had in the **PAST** year.

- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma/COPD
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Eating Disorders
- ☐ Epilepsy
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Psychiatric Care
- ☐ Sexually Transmitted Disease (STD)
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tuberculosis
- _____
- _____
- _____
- _____

FAMILY HISTORY

ID# _____

Have any of your relatives maternal/paternal had any of the following conditions?
If so, please check ☑ and state which relative(s) have/had the condition.

CONDITION	RELATIVE(S)	CONDITION	RELATIVE(S)
☐ Cancer, Breast		☐ Heart Disease, strokes	
☐ Cancer, Lung		☐ High blood pressure	
☐ Cancer, Ovarian		☐ Kidney Disease	
☐ Cancer, Other		☐ Osteoporosis	
☐ Chemical dependency		☐ Other	
☐ Diabetes			

LIFESTYLE

Check ☑ information that applies to your current and last year's experiences.

☐ Alcohol use _____ Drinks per week _____
☐ Caffeine use _____ Cups per week _____
☐ Street drug use _____ Type _____
☐ Tobacco use _____ Packs per day _____
☐ Unusual stress _____
☐ Other _____

Do you take calcium supplements? ☐ Yes ☐ No

What is your level of exercise? ☐ Good ☐ Fair ☐ Poor

Describe _____

HOSPITALIZATION & SURGERIES

Year _____ Hospital _____

Reason for hospitalization/or type of surgery:

Year _____ Hospital _____

Reason for hospitalization/or type of surgery:

Year _____ Hospital _____

Reason for hospitalization/or type of surgery:

SYMPTOMS / CONDITIONS

Check ☑ symptoms you currently have or have had in the past year.

GYNECOLOGICAL
☐ Breast lump
☐ Decreased libido
☐ Hot flashes
☐ Increased vaginal discharge
☐ Nipple discharge
☐ Painful intercourse
☐ Unpleasant vaginal odor
☐ Vaginal infections
☐ Vaginal itching or burning

GENERAL
☐ Chills
☐ Depression
☐ Dizziness
☐ Fainting
☐ Fever
☐ Forgetfulness
☐ Headaches
☐ Loss of sleep
☐ Loss of weight
☐ Nervousness
☐ Numbness
☐ Sweats

CARDIOVASCULAR
☐ Chest pain
☐ High blood pressure
☐ Irregular heart beat
☐ Low blood pressure
☐ Poor circulation
☐ Rapid heart beat
☐ Swelling of ankles
☐ Varicose veins

EYE, EAR, NOSE, THROAT
☐ Bleeding gums
☐ Blurred vision
☐ Difficulty swallowing
☐ Hoarseness
☐ Loss of hearing
☐ Nosebleeds
☐ Persistent cough
☐ Ringing in ears
☐ Sinus problems

GENITO-URINARY
☐ Blood in urine
☐ Frequent urination
☐ Painful urination
☐ Lack of bladder control

MUSCLE / JOINT / BONE
☐ Arms
☐ Hips
☐ Back
☐ Legs
☐ Feet
☐ Neck
☐ Hands
☐ Shoulders

SKIN
☐ Bruise easily
☐ Hives
☐ Itching
☐ Change in moles
☐ Rash
☐ Scars
☐ Sore that won't heal

GASTROINTESTINAL
☐ Appetite Poor
☐ Bloating
☐ Bowel changes
☐ Constipation
☐ Diarrhea
☐ Excessive hunger
☐ Excessive thirst
☐ Gas
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Rectal bleeding
☐ Stomach pain
☐ Vomiting
☐ Vomiting blood