CAPITAL HEALTH CENTER FOR WOMEN'S HEALTH

COMPREHENSIVE MEDICAL HISTORY

Name: ____________________

Date of Birth: ____________________

Today's Date: ____________________

I am here today for (check one): ☐ complete physical ☐ gynecology ☐ other   Age: ________

Prescriptions	Dose	How often

Over the Counter Products/ Vitamins/Supplements*	Dose	How often

Use a separate sheet if your lists do not fit in space provided

Vaccination	Date	Had disease
Tetanus		
Chicken Pox		
Menigococcus		
Hepatitis A		
Hepatitis B		
Pneumonia		
Flu		
Shingles		
Measles/Mumps/Rubella		
HPV		
Tuberculosis (PPD)		
Other (name)		

ALLERGIES to medications/dyes/ shellfish/etc	Describe reaction

Social History

Marital status: ☐S ☐M ☐D/S ☐W ☐Cohabitating

Children: #   Grandchildren: #

Occupation: ☐Retired

Occupational exposures (chemicals/fumes/asbestos/etc):

Military history:

Do you have: ☐Living Will ☐Advance Directive ☐ Donor Card

Screening Tests: Fill in the MOST RECENT date underneath the tests that apply to you

Pap Smear	Mammogram	Bone Density	Colonoscopy	EKG	Cardiac stress test

Prevention

Cigarette use: ☐ never smoked ☐ currently smoke ☐ past smoker; final quit date:

If current or past smoker: average # packs per day: total # of years smoked :

Alcoholic beverages: # drinks per week: ☐Beer ☐ Wine ☐ Liquor

Street drug use (current or past): ☐marijuana ☐heroin ☐cocaine/crack ☐amphetamines ☐other (specify):

Would you like to talk with a counselor about quitting tobacco, alcohol, or drugs ☐YES ☐No ☐ n/a

Caffeinated beverages (coffee, tea, cola, etc) # drinks per day:

Exercise: # times per week ________ for _______ minutes each time. Type of activity:

Blood or blood product transfusion: ☐never ☐date(s) & reason

Seatbelt use: ☐ always ☐sometimes ☐never

Bicycle helmet use: ☐ always ☐ sometimes ☐ never

Sunblock SPF>30 used when exposed to sun: ☐always ☐ sometimes ☐ never

Gun control: Is there a gun in your home? ☐no ☐yes ☐ loaded ☐ out of reach of children

HIV/AIDS: Have you ever engaged in activities which place you at risk for HIV/AIDS? ☐ no ☐yes

Do you have: ☐tattoos ☐body piercing other than ears

Domestic abuse: Have you ever been in a relationship in which you were physically, sexually, or emotionally abused? ☐ no ☐ yes;
If YES, are you safe now? ☐ yes ☐no

STAFF SIGNATURE

Provider Signature and Title   Date and Time

COMPREHENSIVE MEDICAL HISTORY - page 2

Name: ______________________

Date of Birth: ______________________

Today's Date: ______________________

Medical Problems	Date

Operations	Date

Hospitalizations	
Reason	Dates

Family Medical History

☐ Check here if you are adopted

In the space provided, write which family members have (or had if deceased) the condition. Include mother, father,grandparents, siblings, children, other close relatives.

Condition	Family Member	Condition	Family Member
Alcoholism		Genetic diseases	
Anemia		Glaucoma	
Anesthesia problem		Hearing problems	
Arthritis		Heart Problems	
Asthma		High Blood Pressure	
Birth Defects		High Cholesterol	
Bleeding problem		Kidney disease	
Cancer, Breast		Lupus	
Cancer, Colon		Mental retardation	
Cancer, Melanoma		Migraine headaches	
Cancer skin (other)		Mitral Valve Prolapse	
Cancer, Ovary		Osteoarthritis	
Cancer, prostate		Osteoporosis	
Cancer, other		Psychiatric disorder	
Depression/anxiety		Rheumatoid Arthritis	
Diabetes, childhood		Stroke	
Diabetes, adult onset		Thyroid disorders	
Eczema		Tuberculosis	
Epilepsy (seizures)		Other	

For family members that are DECEASED, provide age and cause in the chart below:

Family Member	Age	Cause
Mother		
Father		
Sibling(s)		
Children		
Maternal grandparents		
Paternal grandparents		

STAFF SIGNATURE

Provider Signature and Title ______________________ Date and Time

Name:

Date of Birth:

Today's Date:

COMPREHENSIVE MEDICAL HISTORY - page 3

Provide information about your current and past medical history with a check (✓) as indicated.

	current	past
GENERAL		
Gained or lost more than 10 lbs this year		
Appetite good		
Sleep well		
Awaken frequently during the night		
Snore		
Fatigue		
Awaken rested		
Seasonal allergies		
NEUROLOGICAL		
Frequent headaches		
Migraines		
Seizure		
Tremors		
Lost consciousness		
Paralyzed		
Weakness or numbness of arms or legs		
Concussion		
Dizzy spells		
Memory problems		
CARDIOVASCULAR/ PULMONARY		
Chest pains		
Palpitations		
Shortness of breath climbing 1 flight		
Ankle swelling		
Heart murmur		
Rheumatic fever		
Calf pain with walking		
High blood pressure		
High cholesterol		
Persistent cough		
Asthma		
Pneumonia		
Sleep apnea		
GASTROINTESTINAL		
Abdominal pain		
Ulcers		
heartburn/reflux		
Gallbladder		
Constipation/diarrhea		
Blood in stool (red)		
Black stools		
Hemorrhoids		

FOR STAFF ONLY

Provider Signature and Title

Date and Time

	current	past
UROLOGICAL		
Bladder infections		
Blood in urine		
Kidney infections		
Kidney stones		
Leakage of urine		
Nighttime urination >1 per night		
MUSCULOSKELETAL		
Back pain		
Joint pain/arthritis		
Tendonitis/bursitis		
Gout		
SKIN		
Eczema / seborrhea / psoriasis		
Other skin rash		
Mole removal		
Skin cancer		
ENDOCRINE		
Diabetes (sugar)		
Thyroid, goiter		
Other		
BEHAVIORAL		
Depression		
Postpartum depression		
Anxiety		
Bipolar		
Schizophrenia		
Eating disorder		
Hospitalizations for any of the above		
CANCER: *Specify type.*		
Other issues:		

Name: ______________________
Date of Birth: ______________________
Today's Date: ______________________

COMPREHENSIVE MEDICAL HISTORY - page 4

Provide information about your current and past medical history with a check (✓) as indicated.

MENSTRUAL HISTORY	✓ CHECK
Age menstrual periods began	
Age menstrual periods ended ☐ menopause ☐ hysterectomy ☐ other	
Last menstrual period (date)	
Have you had vaginal sex without birth control since your last period	
How many days does your period last for	
How many days are there in between periods	
Unusual or missed periods in past year	
Bleeding between periods	
Severe Cramps	
Premenstrual syndrome(mood changes or irritability prior to periods so severe it affects your functioning/relationships/etc)	
Lower abdominial pain or pressure	

PELVIC HISTORY	
Last pap smear (date)	
Abnormal Pap smear (in past) If YES: Date_______ Diagnosis________ Treatment_________	
Vaginal itching/burning/sores/rash	
Vaginal discharge that is new or unusual	
Ever infected with (circle any that apply): yeast, bacterial vaginosis, herpes, chlamydia, gonorrhea, trichomonas, genital warts, syphillis, PID	
Bleeding or pain with sex	
Uterine Growth/Fibroids/Ovarian Cyst	
If born before 1971, did your mother take the drug DES during pregnancy?	

PREGNANCY HISTORY	
Ever been pregnant; Date of last completed pregnancy _____________	
Medical problems (you or baby) during pregnancy	
Number times pregnant	
Number live births ☐ Vaginal ☐ C-section	
Number miscarriages/stillbirth	
Number abortions	
Number tubal (ectopic)	
Number premature	
Tried to get pregnant but could not	
Have you used fertility medications and/or needed medical assistance to become pregnant	
Desire future pregnancies	

SEXUAL HISTORY	
Age of first intercourse (vaginal or anal)	
Sexual partners ☐ Male ☐ Female ☐ Both ☐ Bisexual	
Type of sex (now or past): Mark all that apply ☐ Vaginal ☐ Oral ☐ Anal	
More than one partner or new partner in last year	
Any of your partners have/had sexually transmitted infection	
Any of your partners bisexual	
Any of your partners (current and/or past) use/have used intravenous (IV) drugs	
Sexual concerns (for example, low sex drive, difficulty achieving orgasm, etc)	

FOR STAFF ONLY

____
Provider Signature and Title

____
Date and Time

COMPREHENSIVE MEDICAL HISTORY - page 5

Provide information about your current and past medical history with a check (✓) as indicated.

CONTRACEPTIVE HISTORY	✓ CHECK
Current birth control method	
Are you satisfied with your birth control method ☐ Yes ☐ No	
Birth control methods CURRENT or PAST (check all that apply):	
Pills	
DepoProvera	
Nuvaring	
Implanon	
Ortho Evra/Lunelle/Norplant	
IUD/IUS (Copper T/Mirena)	
Diaphragm	
Condoms ☐ Check if you consistently use condoms to prevent STI	
Foam/Sponge	
Tubal ligation/vasectomy	
Natural Family Planning	
Abstinence	
Other	

MENOPAUSAL SYMPTOMS THAT ARE CAUSING PROBLEMS FOR YOU	
Hot Flashes	
Night Sweats	
Vaginal Dryness	
Mood Changes	
Other (describe)	
Have you EVER taken hormone therapy?	

BREAST CANCER RISK ASSESMENT TOOL	
Age at first live birth	
Personal history of breast cancer	
First degree relative (mother, sister, daughter) with breast cancer	
Breast biopsies	
Atypical hyperplasia on breast biopsies	
Radiation (for example to treat lymphoma, cancer) to the neck or chest	
Breastfeeding currently or in the past (decreases risk)	

OSTEOPOROSIS RISK ASSESMENT TOOL	
Previous bone fracture > 40 years old	
Parent fractured hip	
Current smoking	
Steroid use	
Rheumatoid arthritis	
More than 3 alcoholic beverages each day	

FOR STAFF ONLY

Provider Signature and Title

Date and Time

Your signature below is accepted as certification that all information contained on these forms are complete and accurate to the best of your knowledge.

Signature *Date* *Time*