Female Health History

Patient Name_____ Date of Birth_____Today's Date_____

Are you allergic to any medication or food?_____

Gynecologic/Obstetric History

Age you started your period?_____First day of last period_____

How many days do you usually bleed?_____Are you periods regular?_____

Are there any problems with your period?_____

Have you ever had an abnormal pap smear?_____ If yes, what year?_____

Have you ever been diagnosed with fibroids, ovarian cysts or any female problems?_____

Have you ever been pregnant?_____ If so was your delivery vaginal or c-section?_____

Number of living children?_____Number of abortions?_____Number of miscarriages?_____

Were all children born alive?_____Were there any complications?_____

Dates of deliveries/weights/gender:

_____

_____

Sexual History

Have you ever had sex?_____How old were you when you first had sex?_____

How old is your current partner?_____Do you have sex with males/females/both?_____

Do you use condoms?_____Do you use dental dams?_____When was the last time you had sex?_____

Was it with or without a condom?_____

Contraceptive History

Are you on birth control now?_____ If so, what are you taking/using?_____

Have you had problems with any kind of birth control in the past?_____

Which types of birth control have you tried? _____

Are you interested in starting birth control today, if so which method?_____

Please turn over and complete other side.

(all answers are confidential (17 & above –self-administered)

Patient Medical/Surgical/Dental History. Please check Yes or No.
Have you ever had any of the following?

Frequent headaches	**Yes**	**No**	Surgery/Biopsy	**Yes**	**No**
Eye problems (glasses/contacts)			Overnight stay in the hospital		
Ear problems			Blood transfusion		
Seizures/epilepsy			Immunizations/vaccines		
Thyroid problems			HPV Vaccine		
Heart problems			Sexually transmitted infections		
High blood pressure			Blood clots (legs/lungs/arms)		
Blood disorders (anemia)			Skin problems (eczema)		
Breast problems (lumps, cysts)			High cholesterol		
Asthma/breathing problems			cancer		
Digestive problems/ulcers			Depression/anxiety/suicide attempts/mental health problems		
Bladder/urinary/kidney problems			Smoke cigarettes		
Hepatitis/liver/gallbladder problems			Drugs (marijuana, cocaine, pills, etc.)		
Diabetes/gestational diabetes			Drink alcohol (beer, wine, liquor)		
Bone/back problems or pain			Other medical problems not listed		
Chronic illness			Exposure to lead/environmental risk		
Injuries/accidents/broken bones			Tuberculosis/positive TB test		
Occupational hazards: at work are you exposed to any of the following: Blood Bodily Fluids Asbestos Chemicals Fumes Needles/Sharps					

Does anyone in your immediate family have any of the following? (mother, father, sister, brother, grandparents)

High blood pressure	**Yes**	**No**	High cholesterol	**Yes**	**No**
Heart problems			Tuberculosis		
Stroke			Cancer		
Diabetes			Genetic problems		
Blood Clots			Mental Health Problems		
Other health problems:					

Dental History:

Do you drink tap water or take any fluoride supplements?	**Yes**	**No**
Have you ever had any complications from having dental work done?		
Have you ever had any reactions to medications or anesthesia provided by a dentist?		
Have you had any dental surgeries/biopsies/procedures?		
How many times a day do you brush your teeth?		
How many times a day do you floss?		
How often do you see a dentist?		
When was the last time you saw a dentist?		