

# Deseret Women's Health Care

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Your Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for Visit:  Routine Physical  Problem  Describe Problem: \_\_\_\_\_

<p style="text-align: center;"><b><u>Past Medical History</u></b></p> <p><b>When was your last:</b> <span style="float: right;">Was it normal?</span></p> <p>Pap smear _____ <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Mammogram _____ <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Bone density test _____ <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Colonoscopy _____ <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Cholesterol test _____ <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p><b>Have you ever had?</b></p> <p><input type="checkbox"/> Alcohol/Drug problem</p> <p><input type="checkbox"/> Anemia/Blood disease</p> <p><input type="checkbox"/> Arthritis/Joint pain</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Blood transfusion</p> <p><input type="checkbox"/> Cancer <span style="margin-left: 20px;">When &amp; what type?</span></p> <p>_____</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Domestic violence/Abuse</p> <p><input type="checkbox"/> Eating disorder</p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Fractures _____</p> <p><input type="checkbox"/> Gallbladder problems</p> <p><input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> Hereditary or genetic disease</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> High cholesterol</p> <p><input type="checkbox"/> Kidney/bladder disease</p> <p><input type="checkbox"/> Liver disease/hepatitis</p> <p><input type="checkbox"/> Mental illness</p> <p><input type="checkbox"/> Migraines/Frequent headaches</p> <p><input type="checkbox"/> Osteoporosis</p> <p><input type="checkbox"/> Other lung disease</p> <p><input type="checkbox"/> Phlebitis/Blood clots</p> <p><input type="checkbox"/> Seizures/Neurologic disease</p> <p><input type="checkbox"/> Sexually transmitted infections</p> <p><input type="checkbox"/> Stomach/Intestinal problems</p> <p><input type="checkbox"/> Suicide attempts</p> <p><input type="checkbox"/> Thyroid problems</p> <p><input type="checkbox"/> Trauma</p> <p><input type="checkbox"/> Other</p>	<p style="text-align: center;"><b><u>Surgical History</u></b></p> <p><b>Please list any past surgeries or hospitalizations:</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 20%; text-align: center;">Date</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table> <p style="text-align: center;"><b><u>Current Medications (Include vitamins, herbs &amp; over the counter meds)</u></b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table> <p style="text-align: center;"><b><u>Allergies</u></b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table> <p style="text-align: center;"><b><u>Family History</u></b></p> <p><b>Has any blood relative ever had? (Also list which relative)</b></p> <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Asthma  <input type="checkbox"/> Blood disease  <input type="checkbox"/> Cancer  <div style="margin-left: 20px;"><input type="checkbox"/> Breast</div> <div style="margin-left: 20px;"><input type="checkbox"/> Ovary</div> <div style="margin-left: 20px;"><input type="checkbox"/> Colon</div> <div style="margin-left: 20px;"><input type="checkbox"/> Other</div> <input type="checkbox"/> Depression  <input type="checkbox"/> Diabetes  <input type="checkbox"/> Heart disease  <input type="checkbox"/> Hereditary disease  <input type="checkbox"/> High blood pressure                 </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> High cholesterol  <input type="checkbox"/> Kidney disease  <input type="checkbox"/> Liver disease  <input type="checkbox"/> Lung disease  <input type="checkbox"/> Mental illness  <input type="checkbox"/> Neurologic disease  <input type="checkbox"/> Osteoporosis  <input type="checkbox"/> Phlebitis/Blood clots  <input type="checkbox"/> Stroke  <input type="checkbox"/> Thyroid problems                 </td> </tr> </table>		Date																			<input type="checkbox"/> Asthma <input type="checkbox"/> Blood disease <input type="checkbox"/> Cancer <div style="margin-left: 20px;"><input type="checkbox"/> Breast</div> <div style="margin-left: 20px;"><input type="checkbox"/> Ovary</div> <div style="margin-left: 20px;"><input type="checkbox"/> Colon</div> <div style="margin-left: 20px;"><input type="checkbox"/> Other</div> <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart disease <input type="checkbox"/> Hereditary disease <input type="checkbox"/> High blood pressure	<input type="checkbox"/> High cholesterol <input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Lung disease <input type="checkbox"/> Mental illness <input type="checkbox"/> Neurologic disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Phlebitis/Blood clots <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid problems
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### Menstrual History

How old were you when you had your first period? \_\_\_\_\_

How many days is it from the first day of your period to the first day of your next period? \_\_\_\_\_

How long does your period last? \_\_\_\_\_ days.

Flow:       light       medium       heavy

When was your last menstrual period? \_\_\_\_\_

Have you gone through menopause?     yes     no

At what age? \_\_\_\_\_

Do you have any breakthrough bleeding?     yes     no

### Contraception

What is your current method of preventing pregnancy?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Condoms                    | <input type="checkbox"/> Birth control pill              | <input type="checkbox"/> Withdrawal                     |
| <input type="checkbox"/> Depo-Provera               | Name _____   | <input type="checkbox"/> Natural family planning/rhythm |
| <input type="checkbox"/> Diaphragm                  | <input type="checkbox"/> Birth control patch             | <input type="checkbox"/> Contraceptive foam/jelly       |
| <input type="checkbox"/> IUD - type & date inserted | <input type="checkbox"/> Tubal ligation                  | <input type="checkbox"/> Nuvaring                       |
| _____   | <input type="checkbox"/> None - Not trying for pregnancy | <input type="checkbox"/> Vasectomy                      |
|   | <input type="checkbox"/> None - Trying for pregnancy     | <input type="checkbox"/> Abstinence                     |

### Social History

#### Obstetrical History

Total # of pregnancies \_\_\_\_\_

# of full term births \_\_\_\_\_

# of premature births \_\_\_\_\_

# of abortions \_\_\_\_\_

# of miscarriages \_\_\_\_\_

# of ectopic pregnancies \_\_\_\_\_

# of twins \_\_\_\_\_

# of c-sections \_\_\_\_\_

How many living children  
do you have now \_\_\_\_\_

Type of work: \_\_\_\_\_

Do you smoke?     yes     no

If yes, how many packs per day? \_\_\_\_\_

If no, have you ever been a smoker?     yes     no

If yes, how many packs per day did you smoke? \_\_\_\_\_

When did you quit? \_\_\_\_\_

Do you drink alcohol?     None  
                                   Minimal  
                                   Social  
                                   Daily  
                                   Is a problem in my life

Do you use recreational drugs?     yes     no

Do you exercise?       Active but no formal exercise  
                                   Do not exercise/sedentary  
                                   Less than 3 times per week  
                                   More than 3 times per week

#### Marital Status

- Married
- Single
- Divorced
- Engaged
- Co-habiting
- Separated
- Widowed