MRN:
NAME:
DOB:
PCP:

WOMEN'S HEALTH MEDICAL HISTORY FORM

Age: __________

Medical Record Number: FOR OFFICE USE

Patient Name:

Birth Date: ____________________

Today's Date: 11/11/2022

What is the main reason for today's visit ? (List below or check boxes on the right)

☐ PAP Smear
☐ Breast Exam
☐ Mammogram
☐ Birth Control Pills
☐ Hormone Medication
☐ Vaginal Infection

Obstetrical History ☐ NEVER PREGNANT (G ____ P ______________)

How many times have you been pregnant? _____
How many children have you delivered? _____
How many were born full term (37 weeks or greater)? _____
How many were premature (less than 37 weeks)? _____

How many miscarriages did you have? _____
How many abortions did you have? _____
How many children are currently living? _____
How many sets of twins? _____

Gynecologic & Menstrual History

When was the First Day of your Last Menstrual Period? _____/_____/_____ ☐ NONE

What age did you have your First Menstrual Period? _____ years old

When was your last PAP Smear? (OK to give approximate date) _____/_____/_____ ☐ NEVER DONE
My last PAP Smear was ☐ normal or ☐ abnormal or ☐ I don't know
Have you ever had any Abnormal PAP Smears? ☐ Yes ☐ No

When was your last Mammogram? (OK to give approximate date) _____/_____/_____ ☐ NEVER DONE
My last Mammogram was ☐ normal or ☐ abnormal or ☐ I don't know

Check the following Infections or Sexually Transmitted Disease (STD or Venereal Disease) you have had in the past.
☐ NONE EVER ☐ Hepatitis (☐ B or ☐ C) ☐ Bacterial Vaginosis (Gardnerella) ☐ Others: ______________
☐ Chlamydia ☐ Syphilis ☐ Human Papilloma Virus (HPV)
☐ Gonorrhea (GC, Clap) ☐ Trichomoniasis ☐ Herpes (☐ Genital or ☐ Oral)

How many Sexual Partners in your lifetime? (Optional question) ☐ 0 ☐ 1 - 4 ☐ 5 or greater

Currently Sexually Active? ☐ Yes ☐ No

What form of Birth Control are you using?
☐ NONE
☐ Rhythm Method / Natural Family Planning
☐ I had a Tubal Sterilization (Tubes Tied)
☐ I had a Hysterectomy (Uterus removed)
☐ My partner had a Vasectomy
☐ Condoms
☐ Withdrawal
☐ Spermacide
☐ Norplant
☐ Diaphragm
☐ IUD
☐ Depo-Provera Shots (Date last shot given: ____________)
☐ Contraceptive Film
☐ Birth Control Pills (Brand: ______________________________)
☐ Birth Control Patch
☐ Birth Control Ring
☐ Other: ______________________________

Have you gone through Menopause? ☐ No, ☐ Yes (What age? ________) Hormone Medicine: ______________________________

____

Medical History (Check your following Medical Problems) ☐ NO MEDICAL PROBLEMS EVER DIAGNOSED

☐ Breast Cancer (Mo/Yr: _______)
☐ Ovarian Cancer (_______)
☐ Colon Cancer (_______)
☐ Uterus Cancer (_______)
☐ Cervix Cancer (_______)
☐ Other Cancer: ______________
☐ Chemotherapy
☐ Radiation Therapy
☐ Blood Clots
Where? ______________
☐ Stroke
☐ Anemia

☐ Diabetes
☐ High Blood Pressure
☐ Mitral Valve Prolapse
☐ Heart Disease
☐ Irregular Heart Rate
☐ High Cholesterol
☐ Asthma
☐ Low Thyroid
☐ High Thyroid
☐ Migraines
☐ Seizure Disorder
☐ Glaucoma

☐ Loss of Urine Control
☐ Blood in Urine
☐ Frequent Bladder Infection
☐ Vaginal Dryness / Itching
☐ Frequent Vaginal Infection
☐ Painful Intercourse
☐ Pelvic Inflammatory Disease / PID
☐ Abnormal Heavy Vaginal Bleeding
☐ Uterine Fibroids
☐ Fibrocystic Breasts
☐ Nipple Discharge
☐ Cervical Dysplasia

☐ Osteoporosis or ☐ Osteopenia
☐ Arthritis
☐ Depression
☐ Anxiety
☐ Sexual Abuse
Are You Safe Now? ☐Y ☐N
☐ Domestic Abuse
Are You Safe Now? ☐Y ☐N
☐ Psychiatric Problems

☐ Others: ______________

THIS FORM IS CONFIDENTIAL AND PART OF YOUR MEDICAL RECORDS

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OPTUMCare®

MRN:
NAME:
DOB:
PCP:

Patient Name: ______________________ Birth Date: ______________ Medical Record Number: ______________ FOR OFFICE USE

Surgical History (Check the following Surgeries or Procedures) ☐ NEVER HAD ANY SURGERY

☐ Tubal Ligation
☐ Cesarean Section
☐ Hysterectomy (Year: __________)
(Reason: __________)
(☐ Abdominal or ☐ Vaginal)
☐ Myomectomy, Fibroid Removal
☐ Ovaries removed
(☐ Both, ☐ Lt., ☐ Rt.)
☐ Ovary cyst removal surgery
(☐ Both, ☐ Lt., ☐ Rt.)
☐ Ectopic Pregnancy surgery
(☐ Abdominal, ☐ Laparoscopic)
(☐ Both, ☐ Lt., ☐ Rt.)
☐ Bladder surgery
Cervix surgery:
☐ Cryotherapy (Freezing)
☐ LEEP (Heated Wire)
☐ Conization (Cold Knife Cutting)

☐ Laparoscopy
☐ D&C (Dilatation & Curettage)
☐ Hysteroscopy
☐ Endometrial Ablation
☐ Vaginal surgery
☐ Breast lump removal
(☐ Both, ☐ Lt., ☐ Rt.)
(☐ Benign or ☐ Malignant)
☐ Mastectomy
(☐ Both, ☐ Lt., ☐ Rt.)
☐ Breast Implants, or ☐ Reduction
☐ Tonsillectomy
☐ Thyroid surgery
☐ Heart surgery
☐ Stomach surgery
☐ Lung surgery
☐ Liver surgery

☐ Gallbladder surgery
☐ Appendectomy (Appendix)
☐ Splenectomy (Spleen)
☐ Umbilical Hernia Repair
☐ Abdominoplasty (Tummy Tuck)
☐ Colon surgery
☐ Colonoscopy (Date: ______________)
☐ Sigmoidoscopy (Date: ______________)
☐ Hemorrhoid surgery
☐ Lower GI - Barium Enema
☐ Bone Fracture surgery (Which bones? ____)
☐ Spinal surgery (Level:)

☐ DEXA Bone Density Scan (Date: ______________)

☐ Others: ______________________

Family History (Check the following Cancers or List Medical Conditions found in a Family Member)

	Yes	None	Age	Relation (Grandparents, Father/Mother, Brother/Sister, Children, Etc.)
Breast Cancer	☐	☐	____	
Ovarian Cancer	☐	☐	____	______________________
Colon Cancer	☐	☐	____	______________________

Other Medical Problems in the Family:

____

Social History (Check appropriate boxes)

Marital Status: ☐ Single ☐ Married ☐ Living with Partner ☐ Widowed ☐ Divorced / Separated

Occupation: ☐ Homemaker ☐ Student ☐ Retired

Do you smoke tobacco / cigarettes? ☐ No ☐ Yes: _____ (☐ packs or ☐ cigarettes) per (☐ day or ☐ week) ☐ Quit (Date: _______)

Do you drink alcohol? ☐ No ☐ Yes: _____ drinks per (☐ day or ☐ week) ☐ Social, Rarely ☐ Quit (Date: _______)

Which illicit drugs have you used? (Optional question) ☐ NONE ☐ Marijuana ☐ Cocaine, Crack ☐ Ecstasy, MDMA ☐ Methamphetamine ☐ PCP, LSD ☐ Morphine, Heroin ☐ Others: _________ ☐ Quit using all illicit drugs

*What **MEDICATIONS** are you currently taking?* ☐ NOT TAKING ANY MEDICATIONS

Medication Name	*Dosage (mg, gram, IU, etc.) & Frequency (once or twice a day, etc.)*	*Medication Name*	*Dosage (mg, gram, IU, etc.) & Frequency (once or twice a day, etc.)*

*List **MEDICATIONS** you are **ALLERGIC** to and your **REACTIONS**.* ☐ NO KNOWN DRUG ALLERGIES

Allergic Medication Name:	*Type of Reaction (rash, hives, throat swelling, shortness of breath, etc.):*

☐ LATEX ALLERGY

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Patient Signature: ______________________ Medical Provider Signature: ______________________

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