Southwest Medical®
Part of OptumCare®

OPTUMCare®

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
- ☐ Chlamydia
- ☐ Gonorrhea (GC, Clap)
- ☐ Hepatitis (☐ B or ☐ C)
- ☐ Syphilis
- ☐ Trichomoniasis
- ☐ Bacterial Vaginosis (Gardnerella)
- ☐ Human Papilloma Virus (HPV)
- ☐ Herpes (☐ Genital or ☐ Oral)
- ☐ Others: _____

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
- ☐ LowThyroid
- ☐ 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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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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