Southwest Medical®
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OPTUM Care®

MRN: 4289193
NAME: Test, Amy
DOB: 09/17/1981
PCP:

WOMEN'S HEALTH MEDICAL HISTORY FORM

Age: 41

Medical Record Number: 4289193
FOR OFFICE USE

Patient Name: Test, Amy
Birth Date: 09/17/1981
Today's Date: 7/6/2022

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
☐ 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: ____________

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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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