PREVENTIVE WOMEN'S HEALTH
874 FOX DRIVE
WINCHESTER, VA 22603

Name: _____ Birth date: ____ / ____ / ____
Last First Middle Month Day Year

FAMILY HISTORY

HAVE ANY OF YOUR RELATIVES EVER HAD ANY OF THE FOLLOWING?

1) Epilepsy
2) Headaches
3) Mental Illness (depression/anxiety/ other)
4) Kidney Disease
5) Diabetes
6) Thyroid Disease
7) Hayfever
8) Asthma
9) Anemia
10) Bleeds Easily
11) Osteoporosis
12) Arthritis
13) Heart Disease
14) Stroke
15) High Blood Pressure
16) High Cholesterol
17) Alcohol/Drug Addiction
18) Hepatitis
19) Cancer
20) Tuberculosis
21) HIV

Mother: _____
Father: _____
Brother: _____
Sister: _____

MEDICAL HISTORY

ALLERGIES: Do you have any allergies to:

Medications (please list) _____
Food _____
Environmental _____
Latex _____

MEDICATIONS TAKEN REGULARLY: (include allergy shots, birth control, pain control, laxatives, vitamins, diet pills, antidepressants, inhalers, etc.)

Name of Provider prescribing medication: _____ Phone: _____
Medication/Dosage: _____
Medication/Dosage: _____

SURGERIES/ACCIDENTS/HOSPITALIZATIONS: _____

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

- ☐ Decreased hearing
- ☐ Ringing in ear ☐ Ear infections
- ☐ Dizzy spells ☐ Fainting spells
- ☐ Vision problems
- ☐ Severe head injury / concussion
- ☐ Nose bleeds - *recurrent*
- ☐ Sinus trouble
- ☐ Sore throats - *frequent*
- ☐ Hoarseness - *prolonged*
- ☐ Hayfever / Allergies
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic cough
- ☐ Asthma / Wheezing
- ☐ Shortness of breath:
  - ☐ on exertion ☐ lying flat
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Heart murmur ☐ Swollen ankles
- ☐ Irregular pulse ☐ Palpitations
- ☐ Leg pain - *when walking*
- ☐ High cholesterol
- ☐ Cold, numb feet or hands
- ☐ Hair loss
- ☐ Loss of appetite - *recent*
- ☐ Difficulty swallowing
- ☐ Heartburn ☐ Peptic ulcer
- ☐ *Persistent* nausea / Vomiting
- ☐ Abdominal pain - *chronic*
- ☐ Gall bladder trouble
- ☐ Jaundice / Hepatitis
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis ☐ Crohn's /Colitis
- ☐ Bloody or tarry stools
- ☐ Hemorrhoids ☐ Hernia
- ☐ Urinating frequently
  - ☐ with leakage ☐ with pain
- ☐ Blood in urine ☐ Kidney stones
- ☐ Urine infections - *frequent*
- ☐ Sexually transmitted diseases
  - Type: _____
- ☐ Weight-loss ☐ Gain - *recent*
- ☐ Anemia ☐ Bruise easily
- ☐ Blood transfusions
- ☐ Mononucleosis
- ☐ Cancer ☐ Chronic fatigue
- ☐ Diabetes ☐ Thyroid disease
- ☐ Seizures ☐ Stroke
- ☐ Tremor / hands shaking
- ☐ Numbness / tingling sensations
- ☐ Headaches - *frequent*
- ☐ Arthritis / Rheumatism
- ☐ Back pain - *recurrent*
- ☐ Bone fracture / joint injury
- ☐ Foot pain ☐ Tattoos
- ☐ Rashes ☐ Hives
- ☐ Psoriasis ☐ Eczema
- ☐ Rheumatic fever ☐ Scarlet fever
- ☐ Polio ☐ Mumps
- ☐ Measles ☐ German measles
- ☐ Tuberculosis ☐ Herpes
- ☐ Aids / HIV ☐ Malaria / tropical diseases
- ☐ Sleeping or concentration difficulty
- ☐ Depression ☐ Anxiety
- ☐ Agitation ☐ Suicidal thoughts
- ☐ Self injury/cutting ☐ Suicidal attempts
- ☐ Phobias ☐ Mental illness
- ☐ Feelings of worthlessness
- ☐ History of alcohol / drug addiction
- ☐ Anorexia ☐ Eating disorder
- ☐ Bulimia
- ☐ Emotional / physical / sexual abuse

SOCIAL HISTORY:

Do you now or have you ever consumed:

Cigarettes ☐ Y ☐ N Pk./day ___
Alcohol ☐ Y ☐ N Drinks/wk. ___
Caffeine ☐ Y ☐ N Cups/day ___
Street Drugs ☐ Y ☐ N

: Have you ever...

- ☐ been restricted from sports or physical exercise?
- ☐ fainted during exercise?
- ☐ had chest pain or a racing heart during exercise?
- ☐ wheezed or coughed during exercise?
- ☐ had a family member die of sudden death before age 50?
- ☐ had signs or symptoms of marfans?

FEMALES:

Menstrual flow:

☐ Reg. ☐ Irreg. ☐ Pain / cramps
Days of flow ___ Length of cycle ___
Date - 1st day of last period
_____
☐ Pain / bleeding during or after sex
Number of:
Pregnancies ___ Abortions ___
Miscarriages ___ Live births ___
Birth control method _____
B.C. pill (name) _____
Date of last PAP test _____

Other: _____