### FEMALE MEDICAL HISTORY

This information is confidential and will be used by your medical provider to make sure you get proper care.

- **Q** Yes  **Q** No  Are you allergic to any medications or other substances (foods/latex)? List here:

- **Q** Yes  **Q** No  Do you take medications (over the counter or prescription medicines, vitamins, supplements/herbs, or home remedies)? List here:

- **Q** Yes  **Q** No  Do you have a doctor that you go to for regular care? If yes, who?

### A. Family Medical History:

Has anyone in your family Living or Dead (mother, father, brother, sister, or grandparents) ever had:

1. **Q** Heart attack/disease  
2. **Q** Stroke  
3. **Q** High blood pressure  
4. **Q** Diabetes (high sugar)  
5. **Q** High cholesterol  
6. **Q** Breast cancer  
7. **Q** Cancer of the ovaries  
8. **Q** Other cancers  
9. **Q** Birth defects/genetic  
10. **Q** Mental illness  
11. **Q** Lung disease  
12. **Q** Sickle Cell Anemia/Trait  
13. **Q** Blood disease/blood clot  
14. **Q** Thyroid disease  
15. **Q** Mother took hormones (DES) during pregnancy

### B. Personal Medical History:

1. **Q** High blood pressure  
2. **Q** Breast disease  
3. **Q** Cancer – type:__________  
4. **Q** Other cancers  
5. **Q** Birth defects/genetic  
6. **Q** Mental illness  
7. **Q** Lung disease  
8. **Q** Blood clots  
9. **Q** Varicose veins  
10. **Q** Seizures  
11. **Q** Severe headache/migraine  
12. **Q** Vision changes/flashing lights  
13. **Q** Wear glass/contacts  
14. **Q** Blood clots  
15. **Q** Varicose veins  
16. **Q** Seizures  
17. **Q** Depressions/Anxiety  
18. **Q** Eating disorder  
19. **Q** Mental problems  
20. **Q** Anemia (low blood or iron)  
21. **Q** HIV/AIDS  
22. **Q** Sexually Transmitted Disease  
23. **Q** Pelvic infection  
24. **Q** Frequent vaginal infections (yeast/bacteria)

### C. Habits and Life Style

1. **Q** Now  **Q** Never  **Q** In the past  Do you use alcohol? Amount each week? _______ type____________________
2. **Q** Now  **Q** Never  **Q** In the past  Do you use tobacco? If yes, what kind and how much? ____________________________________
3. **Q** Now  **Q** Never  **Q** In the past  Do you use street drugs? If yes, please list ____________________________________
4. **Q** Now  **Q** Never  **Q** In the past  Have you ever injected drugs and/or shared needles?
5. **Q** Now  **Q** Never  **Q** In the past  Is anyone, including your partner, threatening you, causing you to be afraid, or hurting you physically?
6. **Q** Now  **Q** Never  **Q** In the past  Have you ever been pressured or forced to have sex when you did not want to?
7. **Q** Now  **Q** Never  **Q** In the past  Does someone make you feel threatened?
D. Sexual History

1. How old were you when you first had sex? _____ years old  □ I have never had sex
2. How many sexual partners have you had? _____ With: □ women □ men □ both
3. Have you had sexual relations with someone who has been exposed to HPV, genital warts or cervical cancer?
   □ Yes □ No □ I do not know
4. Do you think that your sexual partner currently has other sexual partners? □ Yes □ No □ Not sure

E. Gynecological History:

1. When was your last period or bleeding? (date it started) _______________
2. At what age did your menstrual cycle (periods) start? _______________
3. How often do you have a period? ______ How many days do you usually bleed? ______
4. How much do you bleed? □ Heavy □ Medium □ Light  Do you have cramps? □ Yes □ No
5. Have you ever had a pap smear? □ Yes □ No  
   If yes, when was your last one? ______ Results? _______________
6. Have you ever had abnormal pap smear results? □ Yes □ No
   If yes, when and what was done? _______________________________________
7. Have you ever had a mammogram? □ Yes □ No  If yes, date of last mammogram: ______________
8. What birth control are you and your partner(s) currently using? _______________
   □ None
9. What birth control method would you like to use now? _______________
10. What birth control method(s) have you used in the past? _______________
11. Have you had any problems using birth control in the past? _____ If yes, what? __________________________
12. When do you want to become pregnant? _______________  How many children do you want? _______
13. Have you ever been pregnant? □ Yes □ No  (If no, skip to section F)
14. Please list the number of:  Live Births _____ Miscarriages/stillborn _____ Abortions _____ C-Sections _____
   Birth weight of smallest baby: ______________  Birth weight of largest baby: ______________
15. Did you have any problems with your pregnancy? □ Yes □ No
   If yes, what? __________________________________________________
16. Did you have diabetes while you were pregnant? □ Yes □ No
17. Date of your last delivery: _______________  If you gave birth within the past 3 months, list the date of your
   postpartum exam: _______________  Doctor: __________________________
18. Are you breastfeeding now? □ Yes □ No

F. Present Problems:

1. Are you having any of these problems NOW?: (Check all that apply)
   A. □ Breast lump(s)  D. □ Change in skin on breast(s)  G. □ Pain or bleeding with sex
   B. □ Nipple discharge  E. □ Vaginal itching / burning  H. □ Other sex problems
   C. □ Change in nipples  F. □ Unusual or bad smelling discharge  I. □ Spotting or bleeding between periods

G. Other:

1. □ Yes □ No  Is there anything else about your health or sexual practices that you would like to discuss with your
   clinician today? __________________________________________________

Patient Signature/Date ___________________________  Staff Signature/Title/Date ___________________________

Provider Signature/Title/Date ___________________________  Translator Signature/Date ___________________________

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