Chattanooga-Hamilton County Health Department

PAL Label

DATE:

FEMALE MEDICAL HISTORY

Provider notes:

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

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

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

❑ Yes ❑ 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. ❑ Heart attack/disease
2. ❑ Stroke
3. ❑ High blood pressure
4. ❑ Diabetes (high sugar)
5. ❑ High cholesterol
6. ❑ Breast cancer
7. ❑ Cancer of the ovaries
8. ❑ Other cancers
9. ❑ Birth defects/genetic
10. ❑ Mental illness
11. ❑ Lung disease
12. ❑ Sickle Cell Anemia/Trait
13. ❑ Blood disease/blood clot
14. ❑ Thyroid disease
15. ❑ Mother took hormones (DES) during pregnancy
16. ❑ I don't know my family history
17. ❑ I was adopted

B. Personal Medical History:

1. Have YOU ever had problems with any of these? Check all that apply.

A. ❑ High blood pressure
B. ❑ Stroke
C. ❑ High cholesterol
D. ❑ Heart disease
E. ❑ Diabetes (high sugar)
F. ❑ Thyroid disease/Goiter
G. ❑ Liver disease/Hepatitis
H. ❑ Gallbladder disease
I. ❑ Ulcers/stomach problems
J. ❑ Kidney disease
K. ❑ Lung disease/Asthma/TB
L. ❑ Cancer – type:___________
M. ❑ Breast disease
N. ❑ Breast surgery
O. ❑ Breast implants
P. ❑ Blood clots
Q. ❑ Varicose veins
R. ❑ Seizures
S. ❑ Severe headache/migraine
T. ❑ Vision changes/flashing lights
U. ❑ Wear glass/contacts
V. ❑ Sickle Cell Anemia or Trait
W. ❑ Anemia (low blood or iron)
X. ❑ HIV/AIDS
Y. ❑ Sexually Transmitted Disease
Z. ❑ Pelvic infection
AA. ❑ Frequent vaginal infections (yeast/bacteria)
BB. ❑ HPV or Genital Warts
CC. ❑ Depression/Anxiety
DD. ❑ Eating disorder
EE. ❑ Mental problems

2. ❑ Yes ❑ No Have you ever been hospitalized or had any surgery?
   If yes, when and why? ______________________
3. ❑ Yes ❑ No Have you had a hysterectomy? If yes, date _____________ Type ________________
4. ❑ Yes ❑ No Have you had a tubal ligation/sterilization/essure? ❑ Yes ❑ No
5. ❑ Yes ❑ No Have you had your immunizations (shots) especially:
   Measles/Rubella (MMR)? ❑ Yes ❑ No ❑ I do not know
   Hepatitis B? ❑ Yes ❑ No ❑ I do not know
   Chickenpox vaccine or disease? ❑ Yes ❑ No ❑ I do not know
   Tetanus shot? ❑ Yes ❑ No ❑ I do not know
6. ❑ Yes ❑ No Have you ever had an HIV test?
   If yes, when was your last one?______________ Was it: ❑ Positive ❑ Negative

C. Habits and Life Style

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

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Provider notes:

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 you have had a pap smear, 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)
   - B. ❑ Nipple discharge
   - C. ❑ Change in nipples
   - D. ❑ Change in skin on breast(s)
   - E. ❑ Vaginal itching / burning
   - F. ❑ Unusual or bad smelling discharge
   - G. ❑ Pain or bleeding with sex
   - H. ❑ Other sex problems
   - 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? ____

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______________________________ Patient Signature/Date

______________________________ Staff Signature/Title/Date

______________________________ Provider Signature/Title/Date

______________________________ Translator Signature/Date