NAME________________________ **FEMALE HEALTH HISTORY**

Do you have any of these medical conditions?

	Y	N
High blood pressure		
Blockages in heart arteries		
Heart attack		
High cholesterol		
Heart failure		
Blockages in leg arteries		
Atrial fibrillation		
Diabetes		
Overactive thyroid		
Underactive thyroid		
Osteoporosis		
Stroke		
Warning stroke (TIA)		
Cancer		
Seasonal allergies		
Asthma		
Emphysema		
Chronic bronchitis		
Pneumonia		
Sleep apnea		
HIV		
AIDS		
Tuberculosis		
Hepatitis B		
Hepatitis C		
Chicken pox or shingles		

	Y	N
Gastrointestinal reflux		
Ulcer disease		
Liver disease		
Irritable bowel		
Diverticulosis		
Kidney failure		
Kidney stones		
Lose control of urine		
Memory loss		
seizures		
Migraines		
Neuropathy		
Insomnia		
Arthritis		
Chronic back pain		
Gout		
Anemia		
Sickle cell disease		
Clotting problem		
Depression		
Anxiety		
Bipolar		
Schizophrenia		
Tobacco addiction		
Alcoholism		
Drug abuse		
Other:		
Other:		
Other:		
Other:		

Have you had any surgeries?

Surgery	Year	Surgery	Year

Have you been hospitalized?

Reason	Year	Reason	Year

Health problems of related immediate family members (mother, father, sister, brother)

	Y	N	Whom?		Y	N	Whom?
High blood pressure				Seasonal allergies			
Heart attack				Mental illness			
High cholesterol				Bleeding disorder			
Heart failure				Clotting disorder			
Cancer				Sickle cell			
Stroke				Genetic disorder			
Asthma				Osteoporosis			
Diabetes				Liver disease			
Thyroid disease				Other:			

What was the last grade or level of education you finished?

What is your marital status? Single Married Divorced Separated Widowed Partner

Who lives in your house?

What is your occupation?

Are you exposed to unsafe chemicals or hazards?

Do you smoke?

Do you drink alcohol?

Do you use any street drugs?

Do you have a living will?

Do you have a medical power of attorney?

Menstrual cycle history

Age when periods started	
How often do you get your periods?	
How many days do they last?	
Is the flow light, normal, or heavy?	
Are your menstrual cramps light, normal, or very painful	

Sexual history

Are you sexually active?	Yes	No
Are you and your partner exclusive with each other?		
Do you have sex with men only?		
Do you experience pain with sex?		
Have you noticed problems with interest in sex?		
Have you been treated for a vaginal infection?		
Have you had a sexually-transmitted disease?		

What type of birth control do you use?

Have you had difficulty getting pregnant?

Have you had any problems with your breast?

When was your last mammogram?

Have you had hot flashes or problems with menopause?

Over the last 2 weeks, have you noticed a depressed mood or loss of interest in things you enjoy?

How many times have you been pregnant?

How many babies have you given birth to?

Were any babies premature?

How many children are still living?