PARTNER'S IN WOMEN'S HEALTH
PATIENT HEALTH FORM

While you are being examined by the doctor would you like to have a chaperone?____

Name_____ Date of Birth_____ Date_____

GYNECOLOGIC HISTORY

MENSTRUAL HISTORY

LMP _____ Age at first menses_____ Frequency-every_____ weeks, lasting _____ days

Bleeding: Lt___ Mod___ Heavy___ Do you need pain meds? ____ Type?_____

CONTRACEPTIVE/SEXUAL HISTORY

Are you presently sexually active?____ Are you using any contraceptive method?_____
What type?_____ Have you used other methods in the past (and type)?_____
Any problems?_____
Do you presently have more than one sexual partner? _____ Do you practice "safe sex"?_____
Do you need information on safe sex?_____

STD'S

Have you ever received treatment for a sexually transmitted disease?_____
Which?_____ When?_____ Did you have a follow-up exam?_____

OBSTETRIC HISTORY

Date	# of weeks	Labor (hrs)	Birth Wt	Del. Type	Anesthesia?	Pre Term Labor?	Did you Breastfeed?

Were there any complications of any pregnancy or delivery?_____(Explain below)
Were there problems or birth defects with any of your children?_____(Explain below)
Family members with birth defects?_____

SURGICAL HISTORY
PLEASE LIST

Surgery Date Complications? Any problem with anesthesia?

FAMILY HISTORY
Is there anyone in your family with any of the following (and relationship to you)

Breast Cancer_____ Diabetes_____
Uterine Cancer_____ Colon cancer_____
Ovarian Cancer_____ Osteoporosis_____
Heart Disease, high blood pressure, stroke_____

GENERAL MEDICAL HISTORY
Please list any ongoing medical problems:

Please list all medications, vitamins, supplements that you take on a regular basis

Medication Dosage and Frequency

Are you allergic to any medication? If yes, please list medication and reaction?

Do you smoke? Y N Amount?_____ Would you like to quit? Y N
Do you drink Alcohol? Y N Frequency and amount?_____
Are you concerned about your drinking?_____Your partner's drinking?_____
Do you use an recreational drugs? Y N Which?_____

Do you exercise? Y N Type and how often?_____

IMMUNIZATION HISTORY
If possible, please list dates of last inoculation:
Diptheria/Tetanus booster (Adult DT)_____ Rubella_____ Influenza_____
Hepatitis A_____ Series completed? _____(German Measles)
B_____ Series completed?_____
Gardasil (HPV Vacccine) _____

PAP HISTORY
Date of last Pap smear_____ Result_____
Have you ever had an abnormal Pap?_____ If yes, how was it treated?_____

BREAST
Do you examine your breast every month?_____ Would you like information on self examination?_____
Have you ever had a mammogram?____ If yes, when was the most recent?_____Result:_____
Have you ever had a breast biopsy?_____If yes, when and results:_____

Would you like to discuss any of the following with your doctor?
Menopausal symptoms_____
Problems, gaining, losing or maintaining weight_____
Concerns with sexuality_____
Drug, alcohol or tobacco usage____
History of or continuing problems with abusive behavior of any kind concerning you or anyone in your family_____