Madison Women's Health LLP

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Personal Health History

Full Legal Name (First, Middle, Last)	Name you prefer
Do you have a Living Will or a Durable Power of Attorney for Healthcare? ☐ Yes ☐ No	

Allergies/Reactions – please list all medications, environmental, food etc. AND type of reaction

Current Medications

	Medication	Dose and when taken	For what condition?
Prescribed			

	Medication	Dose and when taken	For what condition?
Over-the-counter, Supplements/Herbals			

Gynecologic/Obstetric History

Age of first menstrual period _____

Usual Cycle Length (days between periods starting) _____

Usual length of flow (in days) _____

Excessively heavy flow? ☐ N ☐ Y

Uses ☐ Pads ☐ Tampons ☐ Both

Significant cramping? ☐ N ☐ Y

Other menstrual problems? Please list below ☐ N ☐ Y

Bleeding between periods? ☐ N ☐ Y

Bleeding after sexual activity? ☐ N ☐ Y

Comments:_____

_____

Please tell us about your pregnancy history. We recognize that pregnancy experiences can be personal or difficult to discuss. Please provider the information you are comfortable sharing.

Total number of pregnancies:

Live births: _____

Still birth: _____

Miscarriage/pregnancy loss: _____

Abortion: _____

Ectopic pregnancy: _____

Molar pregnancy: _____

Other pregnancy outcomes: _____

Number of children currently living: _____

Number of pregnancies that reached 20 weeks or more: _____

Number of pregnancies that ended before 20 weeks: _____

Vaginal births: _____

Cesareans: _____

Obstetric/Gynecology History *(continued)*

Do you have any history of abnormal pap smears?	☐ No ☐ Yes If yes, please list date(s) _____
Any treatment for abnormal pap smears (check all that apply)	☐ Cryo (freezing) Therapy ☐ LEEP ☐ Cone Biopsy ☐ Colposcopy ☐ Repeat PAP
History of Sexually Transmitted Infections (STI)?	☐ N/A ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HPV ☐ Genital Warts ☐ PID ☐ Other _____
Are you sexually active?	☐ No ☐ Yes, with: ☐ men ☐ women ☐ both
Are you using contraception, if needed? ☐ Yes ☐ No ☐ N/A	If so, what method? _____
Do you wish to discuss contraceptive methods?	☐ No ☐ Yes
Do you wish to be screened for any sexually transmitted infections?	☐ No ☐ Yes ☐ Not sure – need more information
Have you ever received HPV-Vaccine?	☐ No ☐ Yes

Past Medical History *(check all that apply)*

Neurologic Conditions	☐ Migraines ☐ Seizure Disorder ☐ Stroke ☐ Nerve Damage ☐ Other: _____
Hematology (Blood) Conditions	☐ Anemia ☐ Excessive Bleeding ☐ Low Platelets ☐ Abnormal Blood Clots ☐ Other: _____
Gastrointestinal Conditions	☐ Constipation ☐ Diarrhea ☐ Irritable Bowel Syndrome ☐ Colitis ☐ Hemorrhoids ☐ Gallbladder problems ☐ Acid Reflux ☐ Stomach ulcers ☐ Diverticulitis ☐ Hepatitis/Liver problems ☐ Colon polyps ☐ Other: _____
Urinary Tract Conditions	☐ Bladder infections ☐ Kidney infections ☐ Kidney stones ☐ Blood in urine ☐ Urinary frequency ☐ Urinary urgency ☐ Urinary incontinence ☐ Other: _____
Cardiovascular Conditions	☐ High blood pressure ☐ Heart disease ☐ Heart murmur ☐ Heart arrhythmia ☐ Cholesterol/lipid problems ☐ Hardening of the arteries ☐ Varicose veins ☐ Other: _____
Respiratory Conditions	☐ Asthma ☐ Recurrent bronchitis ☐ History of smoking ☐ Pneumonia ☐ Secondhand smoke exposure ☐ Sleep apnea ☐ Other: _____
Breast Conditions	☐ Breast pain ☐ Benign breast lumps ☐ Fibrocystic Changes ☐ Breast biopsies ☐ Mastitis ☐ Abnormal mammograms ☐ Breast skin/nipple changes ☐ Other: _____
Metabolic Conditions	☐ Thyroid ☐ Diabetes/Pre-diabetes ☐Polycystic Ovarian Syndrome ☐ Hypoglycemia ☐ Difficulty with Weight Control ☐ Vitamin deficiency ☐ Other: _____
Mental Health Conditions	☐ Depression ☐ Anxiety ☐ Seasonal Affective Disorder ☐ Eating Disorder ☐ Postpartum depression ☐ Suicide attempt ☐ Substance dependence ☐ Sexual assault survivor ☐ Bipolar disorder ☐ ADD/ADHD ☐ Sleep disorder ☐ Other: _____

Orthopedic Conditions	☐ Chronic back pain ☐ Chronic hip pain ☐ Knee problems ☐ Neck problems ☐ Fractures ☐ Arthritis ☐ Sports injury ☐ Other: _____
Rheumatologic Conditions	☐ Rheumatoid Arthritis ☐ Lupus ☐ Lyme Disease ☐ Osteopenia/Osteoporosis ☐ Other: _____
Gynecologic Conditions	☐ Lack of menstrual periods ☐ Irregular menstrual periods ☐ Fibroids ☐ Heavy menstrual flow ☐ Endometriosis ☐ Endometrial polyps ☐ Cervical polyps ☐ Ovarian cysts ☐ Tubal problems ☐ Vaginal dryness ☐ Pelvic prolapse (cystocele rectocele uterine prolapse) ☐ Pelvic pain ☐ Difficult menopausal symptoms ☐ Pain during sexual activity ☐ Vaginal yeast inf. ☐ Bacterial vaginosis (BV) ☐ Vulvar skin problems/irritation ☐ Fertility issues ☐ Other: _____
Dermatologic Conditions	☐ Significant acne ☐ Rashes ☐ Eczema ☐Psoriasis ☐ Abnormal moles ☐ Other: _____
Cancer Conditions	☐ Breast ☐ Colon ☐ Lung ☐ Ovarian ☐ Endometrium (uterus) ☐ Skin ☐ Lymphoma ☐ Leukemia ☐ Oral cancer ☐ Cervical ☐ Other: _____
Infectious Diseases	☐ Mononucleosis ☐ Scarlet Fever ☐ Tuberculosis ☐ MRSA ☐ Tropical diseases ☐ Other: _____

Other significant or past medical condition not listed?

Past Surgeries *(list others on separate sheet and attach to this form)*:

Type of Surgery	Year or Age	Comments/Complications

Obstetrical History---All Pregnancies *(list others on separate sheet and attach to this form):*

Date Pregnancy Ended and Gestational Age	Birth or loss	If Birth, type of delivery	Weight	Male or Female?	Name of child	Any Complications?
	B L	Vaginal Cesarean		M F		
	B L	Vaginal Cesarean		M F		
	B L	Vaginal Cesarean		M F		
	B L	Vaginal Cesarean		M F		
	B L	Vaginal Cesarean		M F		
	B L	Vaginal Cesarean		M F		

Health Maintenance:

☐ See Wisconsin Immunization Registry

	Type	Date	Type	Date	Type	Date
Vaccines	MMR		Meningococcal		Shingles	
	Td (tetanus)		HPV		Pneumovax	
	TdaP		Hepatitis A		Hepatitis B	
	Other					
Screening	Mammogram		Cholesterol		Diabetes/Blood Sugar	
	Bone Density		Colonoscopy		Hepatitis C (if born before 1965)	
	Cervical Cancer		Other			

Health Habits:

Regular use of seat belts? ☐ No ☐ Yes

Smoke detectors? ☐ No ☐ Yes

Carbon monoxide detector? ☐ No ☐ Yes

Bicycle/motorcycle helmets? ☐ No ☐ Yes

Exercise/Physical Activity? Type _____

Frequency _____

If you do not exercise, why? _____

Do you have concerns about your diet? _____

Calcium servings per day _____

What do you do for relaxation? _____

Smoke cigarettes? ☐ Never ☐ Former ☐ Yes, _____ packs per day

Smokeless tobacco ☐ No ☐ Yes Frequency: _____

Marijuana use? ☐ No ☐ Yes ____ times /week

Recreational drugs? ☐ No ☐ Yes Type/frequency: _____

Alcohol? ☐ No ☐ Yes _____ times/ day/week/month

Do you feel safe in your home? ☐ No ☐ Yes

Are there any guns in your home? ☐ No ☐ Yes

Do you have concerns about any of your relationships, especially any you feel are unhealthy? _____

Have you ever been forced to have sexual contact against your will? ☐ No ☐ Yes

Are there any other concerns you would like to discuss with the provider? _____

_____

Family Medical History:

Please list family member affected - (M = Mother, F = Father, S = Sibling, MGM = Maternal Grandmother, MGF = Maternal Grandfather, PGM = Paternal Grandmother, PGF = Paternal Grandfather, O = Other – specify)

High blood pressure		Diabetes		Kidney disease	
Heart disease		Blood clots		Dementia	
Breast Cancer		Colon Cancer		Ovarian Cancer	
Skin Cancer		Uterine Cancer		Bladder Cancer	
Bleeding Difficulties		Osteoporosis		Aneurysms	
Thyroid Problems		Asthma		Severe Allergies	
Substance Abuse		Depression		Bipolar Disorder	
Rheumatoid Arthritis		Other			