Women's Health Associates

A Division of Regional Women's Health Group, LLC

Larry S. Rosen, M.D., F.A.C.O., D.A.B.O.G
Paul J. Zinsky, M.D., D.A.B.O.G
Megan Miller, M.D.
Nicole Freehill, M.D., MPH
Andrea DiBlasio Frake, A.P.N., C.
Meryl Penalver, A.P.N., C.

History Form

Please fill in or check all that apply: **PLEASE PRINT**

Name: _____ DOB: _____

Allergies & Drug Reactions:_____
_____

Medications & Dosages: _____
_____

When was your last: Menstrual Cycle: _____ Pap _____ Mammogram_____
Dexa Scan (bone density scan) _____Colonoscopy _____ Cholesterol _____ Other _____
Do you have menopausal symptoms, if so please list: _____
_____

GYN HISTORY:
*Age of first period _____ How often are menstrual cycles _____ How long does it last _____
*Cramps _____ How heavy _____ Clots _____
*Have you had/have any of the following:
Endometriosis _____ PID _____ Herpes _____ STD's _____ Fibroids _____
Uterine Prolapse _____Other: _____
*Vaccines: HPV _____ Hepatitis B _____ Other _____ Flu vaccine _____
*Do you give self breast exams at home? YES or NO
*Any history of Abnormal Pap Smears? YES or NO

SEXUAL HISTORY
*Do you use any form of birth control? _____
What type? _____(Oral contraceptive, IUD, Condoms, Abstinence, etc.)
*Have you ever been exposed to an STD? Yes_____ No _____
*Have you ever been sexually active? _____ Are you currently sexually active? _____

OBSTETRICAL HISTORY:
How many times have you ever been pregnant? _____ How many full term (37+ wks) children? _____
How many premature (36 wks or less) deliveries? _____How many terminations or miscarriages? _____
If you have had deliveries, list date of births and types (vaginal or c/section or VBAC) _____
_____
List complications of pregnancy (Ex: Preterm labor, diabetes, high blood pressure, bleeding, multiples) _____
_____

FAMILY HISTORY (list relationship, if grandparent list **maternal or paternal, with relationship**)
Does anyone have/had breast cancer? _____ Ovarian cancer? _____Uterine Cancer? _____
Cervical cancer? _____Colon cancer? _____ Any type of cancer?_____
High blood pressure? _____ Heart disease? _____ Strokes? _____
Blood clotting problems? _____Diabetes? _____ Genetic disorders? _____
Other? _____

PLEASE TURN OVER---------->

SOCIAL HISTORY

*Any tobacco use, current or past? _____ How much per day? _____ Do you smoke every day or some days
How long after you wake up do you have your first cigarette?
within 5 minutes, 6-30 minutes, 31-60 minutes, after 60 minutes.
*Do you drink alcohol? YES or NO.
How often? 1 time a month or less, 2-4 times a month, 2-3 times a week, 4 or more times a week.
How many drinks on a typical occasion? 1-2 drinks, 3-4 drinks, 5-6 drinks, 7-9 drinks, 10 or more drinks.
How often do you have 6 or more drinks on one occasion? Never, less than monthly, monthly, weekly, daily.
*Do you use any non prescribed drugs?_____ Have you ever been in treatment for addiction? _____
*How much caffeine do you drink per day? _____ How often do you exercise? _____

GENERAL MEDICAL HISTORY

*Neurological Disorders
Migraines _____ Numbness _____ Stroke _____ Multiple Sclerosis _____ Anxiety _____
Memory loss/ Alzheimer's disease _____ Mental health disorder _____ Depression _____

*Respiratory Disorders
Asthma _____ Emphysema _____ TB _____ Cystic Fibrosis _____

*Breast Disorders
Lumps/masses _____ Cysts _____ Biopsies _____ Cancer _____

*Cardiac Disease
Heart attack _____ Vascular disease _____ High blood pressure _____ Mitral Valve Prolapse _____
Palpitations/Arrhythmia _____ Blood clots _____ Congestive heart failure _____ Other _____

*Gastrointestinal Disorders
Irritable bowel _____ Celiac _____ Colitis _____ Colon cancer _____ Blood in stools _____
Rectocele _____ Crohn's Disease _____ Other _____

*Kidney/Urinary Problems
Kidney stones _____ Kidney disease _____ Incontinence _____ Cystocele/fallen bladder _____
Urinary tract infections _____ Interstitial cystitis _____

*Autoimmune/Hematologic Disorders
Blood clotting difficulty _____ Anemia _____ Sickle cell _____ HIV _____ Lupus _____
Have you ever had a blood transfusion _____ Have you ever hemorrhaged _____

*Muscle or Skeletal Disorder
Arthritis _____ Fibromyalgia _____ Osteoporosis _____ Fractures _____ Spinal/disc disease _____
Muscle weakness/paralysis _____ Problems moving _____

*Endocrine
Thyroid dysfunction_____ Diabetes _____ Polycystic Ovary Syndrome (PCOS)_____
Addison's Disease _____ Graves Disease _____

*Any other medical conditions not listed on this form:

_____

_____

_____

URINARY INCONTINENCE

Do you ever leak urine when you cough, laugh, sneeze, or exercise? YES or NO
Do you ever leak urine trying to get to the bathroom on time? YES or NO
Do you go more than 7 times during the day and/or more then 2 times per night? YES or NO

SURGERIES

List dates and types of any surgeries

_____

_____

_____

HOSPITAL ADMISSIONS:

List dates and reasons for being admitted to the hospital

_____

_____

_____