

# Insight Family Health Center

## FEMALE HEALTH HISTORY

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Living Situation: Spouse \_\_\_\_\_ Alone \_\_\_\_\_ Partner \_\_\_\_\_ Friend(s) \_\_\_\_\_ Parents \_\_\_\_\_ Children \_\_\_\_\_ Other \_\_\_\_\_

What is the reason for your visit today? If it is a problem, please describe the symptoms & be specific: \_\_\_\_\_

\_\_\_\_\_

Please list any allergies you have to food or medications: \_\_\_\_\_

\_\_\_\_\_

Please list any medical problems that you are currently being treated for or have been treated for in the past: \_\_\_\_\_

\_\_\_\_\_

Please list any surgeries that you have had including the date: \_\_\_\_\_

\_\_\_\_\_

Please list any medications and nutritional supplements *with dosages*, prescription or over-the-counter, that you take:

\_\_\_\_\_

\_\_\_\_\_

Do your parents, grandparents, brothers, or sisters have any of the following? (check all that apply)

\_\_\_ Diabetes \_\_\_ Heart Attack \_\_\_ Cancer If so, what type? \_\_\_\_\_ \_\_\_ Stroke  
\_\_\_ High Cholesterol \_\_\_ High Blood Pressure \_\_\_ Blood clots \_\_\_ Heart disease/heart surgery

Age of first period: \_\_\_ Date of last period: \_\_\_\_\_ Date of last pap smear: \_\_\_\_\_ Result: \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_ Result: \_\_\_\_\_ Date of last bone density study: \_\_\_\_\_ Result: \_\_\_\_\_

Date of last sigmoidoscopy/colonoscopy: \_\_\_\_\_ Result: \_\_\_\_\_

Are you sexually active? \_\_\_ YES \_\_\_ NO With males, females, or both? \_\_\_\_\_

If you are still having a period, what is your method of contraception? \_\_\_\_\_

Do you get routine physical exercise? \_\_\_ YES \_\_\_ NO If yes, what type & how long? \_\_\_\_\_

Do you smoke cigarettes? \_\_\_ YES \_\_\_ NO If yes, # per day: \_\_\_\_\_ Number of years: \_\_\_\_\_

Previous smoker? \_\_\_ YES \_\_\_ NO Stop date: \_\_\_\_\_ # per day: \_\_\_\_\_ # of years: \_\_\_\_\_

Do you drink alcohol? \_\_\_ YES \_\_\_ NO If yes, how much per day? \_\_\_\_\_ What type? \_\_\_\_\_

Do you drink caffeine products? \_\_\_ YES \_\_\_ NO If yes, how much per day? \_\_\_\_\_ What type? \_\_\_\_\_