

Circle of Life Women’s Center is happy you have chosen us for your care! To make your upcoming appointment more efficient for you as well as your provider, we ask that you fill out the following health history. You will notice it also includes areas for the problem you wish to address at your visit and your current medication & supplement list. Please bring this completed document to your appointment so that our staff may meet your needs more accurately. If you need additional space for any of the sections below, please attach a separate sheet. ***Before being taken to our Registration area, this document will need to be completed in its entirety.**

Name: _____ DOB: _____

What is the reason for your visit: _____

MEDICAL HISTORY

Please mark all that apply below.

___ No Known Medical History Problems

	<u>You</u>	<u>Family</u>	<u>Details/Comments</u>
AIDS (HIV)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia/Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer (If yes, who & what type?)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression/Anxiety (If yes, family history of depression or suicide?)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Female/Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gall Bladder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease/Stroke/Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney/Bladder/UTI	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pulmonary Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sexual/Domestic Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach or Bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	_____

SUBSTANCE USE

	<u>Yes</u>	<u>No</u>	Details/Comments
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recreational Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____

SEXUAL HISTORY

	<u>Yes</u>	<u>No</u>
Have you ever been sexually active?	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Concerns:		
Pain with intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding with intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a new partner in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any of the following STD's:		
Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>
Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
HPV (Cervical Dysplasia or Genital Warts)	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>
Trichomonas	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>
Other Sexual Concerns? _____		

LIFESTYLE

	<u>Yes</u>	<u>No</u>
Have you ever had a PAP test?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, have you ever had an abnormal PAP?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, did you have a Cryo Surgery (freezing of cervix)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, did you have a Colposcopy (biopsy of cervix)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a mammogram?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when & where? _____		
If yes, results (if known)? _____		
Do you have breast implants?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a dexascan?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when, where, & results? _____		
Have you ever had a colonoscopy?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when, where, & results? _____		
Do you perform monthly self breast exams?	<input type="checkbox"/>	<input type="checkbox"/>
Do you exercise on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>
How many hours of sleep do you receive each night? _____		
How often do you wake during the night? _____		

MENSTRUAL HISTORY

	<u>Yes</u>	<u>No</u>
Are you post menopausal?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a hysterectomy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an ablation?	<input type="checkbox"/>	<input type="checkbox"/>
When was the first day of your last period? _____		
What was your age of first menses? _____		
What is your interval between periods (# of days)? _____		
What is your length of your periods (# of days)? _____		
Do you have spotting in between your periods?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any abnormalities?	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Unusual Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Other Comments/Concerns: _____		

BIRTH CONTROL

Current Contraceptive Method:

- None
- Oral Contraceptive Pill
- IUD
- Depo Provera
- Nexplanon
- Nuvaring
- Condoms
- Tubal Ligation
- Essure
- Hysterectomy
- Post Menopausal
- Vasectomy
- Other: _____

How long have you used your current contraceptive method? _____

Are you satisfied with your current contraceptive method? Yes No

If no, explain? _____

Are you planning a pregnancy? Yes No Uncertain

SURGICAL HISTORY

	<u>Yes</u>	<u>No</u>	Details/Complications
Cardiac Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
ENT (Ear/Nose/Throat) Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____

	<u>Yes</u>	<u>No</u>	Details/Complications
GU (Genitourinary) Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
GI (Gastroenterology) Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
GYN (Gynecology) Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____

PREGNANCY HISTORY

Total # of Pregnancies: _____
 # of Births at or past 37 weeks gestation: _____
 # of Births less than 37 weeks gestation: _____
 Forceps used? Yes No Vacuum used? Yes No
 # of Cesarean Deliveries: _____
 # of Miscarriages: _____
 # of Abortions: _____
 Did you have any of the following pregnancy complications:

	<u>Yes</u>	<u>No</u>	Details/Comments
Preterm labor	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recurrent pregnancy loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Still birth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gestational diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure or pre-eclampsia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Twins or triplets	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Very large baby	<input type="checkbox"/>	<input type="checkbox"/>	_____
Growth restricted baby	<input type="checkbox"/>	<input type="checkbox"/>	_____
Birth defect	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other complications	<input type="checkbox"/>	<input type="checkbox"/>	_____

MEDICATIONS

Please list all of your current medications (prescribed & over the counter). Many medications have similar spelling so please confirm the list below with your actual medication bottles to ensure we update your records accurately. If you need additional space, please attach a separate sheet.

Name	Strength	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SUPPLEMENTS

Please list all of your current supplements. Many supplements have similar spelling so please confirm the list below with your actual supplement bottles to ensure we update your records accurately. If you need additional space, please attach a separate sheet.

Name	Strength	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Please list all of your current allergies:

VACCINATIONS

	<u>Yes</u>	<u>No</u>	<u>Unknown</u>
Have you ever been vaccinated for Hepatitis A or B?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a tetanus shot within the last 10 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had the Gardasil series?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please note your appointment is scheduled for an allotted amount of time. In order for us to remain on schedule, if there are multiple problems you need to address, please prioritize what you wish to discuss today. We will ask you to make a follow-up visit to continue our assessment & treatment for any remaining problems until we have assisted you with all of your concerns. Thank you for assisting us to give you our best & most efficient care!