Circle of Life
Women's Center

**Name:** **Date of Birth:**

| MEDICAL HISTORY | YOU | FAMILY |
|---|---|---|
| Diabetes | □ | □ |
| High Blood Pressure | □ | □ |
| Heart Disease | □ | □ |
| Kidney/Bladder/UTI | □ | □ |
| Neurologic/Epilepsy | □ | □ |
| Psychiatric | □ | □ |
| Liver Disease | □ | □ |
| Thyroid Disease | □ | □ |
| Sexual/Domestic Abuse | □ | □ |
| Blood Transfusions | □ | □ |
| Pulmonary Disease | □ | □ |
| Breast Disease | □ | □ |
| Female/Sexual Problems | □ | □ |
| Tuberculosis | □ | □ |
| Asthma | □ | □ |
| Gall Bladder | □ | □ |
| Stomach or Bowel | □ | □ |
| High Cholesterol | □ | □ |
| Rheumatic Fever | □ | □ |
| Anemia/Blood Disorder | □ | □ |
| AIDS (HIV) | □ | □ |
| Hepatitis | □ | □ |
| Seasonal Allergies | □ | □ |
| Cancer | □ | □ |
| Infertility | □ | □ |
| Blood Clots | □ | □ |

| SUBSTANCE USE | Yes | No |
|---|---|---|
| Alcohol | □ | □ |
| Tobacco | □ | □ |
| Recreational Drugs | □ | □ |
| Other Health Supplements | □ | □ |

| SEXUAL HISTORY | Yes | No |
|---|---|---|
| Have you ever been sexually active? | □ | □ |
| **Sexual Concerns:** | | |
| Pain with intercourse | □ | □ |
| No Sex Drive | □ | □ |
| Bleeding with intercourse | □ | □ |
| Have you had a new partner in the past year? | □ | □ |
| **Have you ever had an STD?** | □ | □ |
| Chlamydia | □ | □ |
| Gonorrhea | □ | □ |
| Trichomonas | □ | □ |
| HPV | □ | □ |
| Genital Herpes | □ | □ |
| HIV | □ | □ |
| Syphilis | □ | □ |
| Hepatitis C | □ | □ |

| LIFESTYLE | Yes | No |
|---|---|---|
| Have you ever had a PAP test? | □ | □ |
| Have you ever had an abnormal PAP? | □ | □ |
| Was your abnormal PAP treated with any of the following: | | |
| Cryosurgery (freezing the cervix) | □ | □ |
| Colposcopy (biopsy of the cervix) | □ | □ |
| Have you ever had a mammogram? | □ | □ |
| If yes, when & where? _____ | | |
| If yes, results (if known)? _____ | | |
| Have you ever had a dexascan? | □ | □ |
| Have you ever had a colonoscopy? | □ | □ |
| Do you do monthly self breast exams? | □ | □ |
| Do you exercise on a regular basis? | □ | □ |

| VACCINATIONS | Yes | No |
|---|---|---|
| Have you ever been vaccinated for: | | |
| Hepatitis A | □ | □ |
| Hepatitis B | □ | □ |

| MENSTRUAL HISTORY | Yes | No |
|---|---|---|
| Post Menopausal or had hysterectomy: | □ | □ |
| First day of last period: | ___/___/___ | |
| Age of first menses: | | |
| Interval (days between periods): | Days: | |
| Length of period: | Days: | |
| Spotting: | □ | □ |
| **Abnormalities:** | | |
| None | □ | □ |
| Excessive Bleeding | □ | □ |
| Pain | □ | □ |
| Unusual Discharge | □ | □ |

| BIRTH CONTROL | Yes | No |
|---|---|---|
| **Current Contraceptive Method:** | | |
| None | □ | □ |
| Oral Contraceptive Pill | □ | □ |
| Depo Provera | □ | □ |
| Condoms | □ | □ |
| Tubal Ligation | □ | □ |
| Hysterectomy | □ | □ |
| Post Menopausal | □ | □ |
| Other: | | |
| How long used: | | |
| Satisfied with current method? | □ | □ |
| Planning pregnancy? | □ | □ |

| SURGICAL HISTORY | Complications: Yes | No |
|---|---|---|
| Cardiac | □ | □ |
| Ear/Nose/Throat | □ | □ |
| Lung | □ | □ |
| Musculoskeletal | □ | □ |
| Genitourinary | □ | □ |
| Gastroenterology | □ | □ |
| Gynecology | □ | □ |
| Breast | □ | □ |
| Other: _____ | □ | □ |

| PREGNANCY HISTORY | | |
|---|---|---|
| # of Pregnancies | # | |
| Births at > 37 weeks: | # | |
| Births at <37 weeks: | # | |
| Forceps/Vacuum used: (circle) | Yes | No |
| Cesarean Deliveries: | # | |
| Miscarriages: | # | |
| Abortions: | # | |
| Pregnancy Complications: | | |

**CURRENT MEDICATIONS (Name, Strength, & Dosage)**

**ALLERGIES**

| | Yes | No |
|---|---|---|
| Have you had a Tetanus shot within the last 10 years? | □ | □ |

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