Female History Form

Morris County Health Department

Client Name	Age	DOB		ID#_		
Reason for today's visit: Are you aller	rgic to any	medicatio	ns, foods,	latex, metals	, or other? _	NoYes
Please list						
General Health						
Have you ever had or do you have: No Yes Diabetes / Thyroid Problems Seizures Heart attacks or strokes Breast surgery or problems Depression Migraines with aura Blood Clot in your blood vessels like leg or lung Blood transfusions Shortness of breath Anemia Have you ever had any other medical conditions, any surgery or been		Cancer High blood Hepatitis (Pelvic infe Uterine fib Problems Eczema o Problems High Chol	d pressure skin turned ction treated roids or ova with vision or r skin proble with muscle esterol	d in the hospit rian cysts or hearing ems s / bones	lbladder probl al	
How many times a week do you exercise? Per day, how many fruits v	/egetables_	dairy_	grains	meat	do yo	ou eat?
Do you chew / smoke tobacco?NoYes If yes how many cigarettes a	day?	How long	nave you ch	ewed / smoke	ed?	
How many alcoholic beverages do you drink per day, week, month?	-		t your alcoh	ol use?N	loYes	
Do you currently use street drugs?NoYes If yes how many tir						
Do you or have you used injectable drugs?NoYes If yes, how often?_						
List the medications you are taking, how often and how much. Include prescription	ions, over th	he counter	(Ibuprofen,	Tylenol), herb	os, & vitamins:	
The date of your last mammogram and results? If age	50 or older	, have you	had colon o	ancer screen	ing?No	 Yes
<u>Immunizations</u> Please give the date of your last immunizations. (A tetanus booster dose is reco	ommended	every 10 y	ears.)			
MMR (1 or 2 doses)Td/TdapHepatitis B, series	HP	V vaccinati	on O	ther, list		
Family History Are you adopted?NoYes (If yes and you do not know Have any of your blood relatives had the following conditions? Please say whoBiabetes High cholesterol / triglyce	they are. (I	nclude you	ır mother, fa	ther, brothers	, and sisters)	
Cancer(type) High blood pressure			Stroke_			
Phlebitis or clots in the veinsat what age	Heart	disease or	heart attacl	ζ	at what	age
If born before 1971, did your mother receive a hormone called Diethylstilbestrol	(DES) while	pregnant	with you? _	NoD	o not know _	Yes
Psychosocial: Do you have any problems at home, work, or school that are bo	thering you	?No	Yes If y	es, please ex	plain	
Menstrual How old were you when your periods began? Date of last period (1st			, ,		NoY	es
How many days does your period last? How many days from the start of Do you bleed between periods? No Yes How many pads/tampons do				хт репоа?	_	
Do you have pain with your periods?NoYes If yes, what to you do to		-				
Do you have menstrual tension, weight gain, backache, or mood changes before						
Pap Smears Is this your first Pap Smear?NoYes (If this is your first pa	an smear, s	kin this sec	ction)			
When was your last Pap Smear? What were the results?				know		
If you have ever had an abnormal Pap Smear when and what treatment:						
Pregnancy Have you ever been pregnant?No (If no, you are done with this section) _ # of pregnancies # of deliveries Date of your last de # of miscarriages # of abortions # of ectopic Describe any complications you had during pregnancy (example: high blood pre Are you currently breastfeeding?NoYes Do you have plans	elivery ssure; depr	ession; hig	# h blood sug	of living child		

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-	ou when you first had in			-			
-		_	or after intercourse			describe	
-	itly been treated for a va	_			-	describe	
-	· · · ·		-		_	_NoYes (list)	
•	•		•				_
		-			-	, when?	
Have you had a	new sexual partner or	more than one sexua	I partner in the last	t year?N	oYes I	How many partners in your lifetime? _	
Were/Are your s	sexual partners: men	□ women □ both □ IV	/ drug users □ parti	ner with mult	iple partners o	r at risk for HIV/STD	
What types of s	ex have you had? Or	al □ Anal □ Vaginal	□ None				
Have your ever	been physically abused	d (hit, kicked, slapped)?	No _	Yes		
Have you ever b	been emotionally abuse	d (threatened, made	to feel worthless)?	No _	Yes		
Has anyone, inc	cluding partner or family	member ever forced	you to have sex?	No _	Yes		
What do you do	to protect yourself from	n being infected with I	HIV/STD?				
AI W N	s birth control methods y bstinence (not having so /ithdrawal orplant / Implanon aginal ring	ex)Pill Cond IUD		onge		Foam, suppository, gel, film Depo Provera Birth Control Patch er	
What is the mos	st recent birth control me	ethod you have used	?				
Are you using th	his method now?N	lo If no, when did you	u stop using it?	Y	es If yes, how	long have you been using it?	_
Have you had p	roblems with any birth o	control methods?	_NoYes If ye	es, describe_			_
Client signatur	re and date				Client signat	ure and date updated	-
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