Dr. Randolph's Ageless & Wellness Medical Center
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FEMALE HEALTH HISTORY FORM

(Please Print Clearly)

Date: ________________

Name: ____ DOB: ________________

Reason for today's visit: ____

____

Height:________________inches

Weight: Usual: __________ Recent Gain: __________ Recent Loss: __________

Allergies (check all that apply and indicate reaction)

- ☐ Aspirin_____________
- ☐ Codeine_____________
- ☐ Novocain____________
- ☐ Shellfish____________
- ☐ Betadine____________
- ☐ Latex_______________
- ☐ Sulfa_______________
- ☐ Other______________

Gynecological History

Age of menstrual period onset ___________________

Are you in menopause? ☐No ☐Yes

If No, please skip to Menstrual Information

At what age did your periods stop? __________

Have you had a hysterectomy? ☐No ☐Yes

If yes, when? __________

Do you have your ovaries? ☐No ☐Yes

Do you have a cervix? ☐No ☐Yes

Are you using Hormone Replacement Therapy?

☐No ☐Yes

If yes, what hormones are you replacing?

☐Progesterone

☐Estrogen

☐Testosterone

Explain______________________________________

____

____

Menstrual Information

Date of last period_____________________________

How long did it last? ___________________________

Are your periods generally regular? ☐No ☐Yes

Do you bleed between periods? ☐No ☐Yes

Do you or did you ever have PMS? ☐No ☐Yes

Method of birth control used ____________________

Pregnancies

How many pregnancies have you had? ___________

How many miscarriages? ______________________

How many children were born alive? _____________

How many abortions? _________________________

How many tubal pregnancies? ___________________

Any complications with pregnancy? ☐No ☐Yes

Explain______________________________________

____

____

Personal Medical History (check all that apply)

- ☐ Abnormal Pap Smears
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis/Gout
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Blood Transfusion
- ☐ Blurred Vision
- ☐ Bronchitis
- ☐ Cancer / type:_________
- ☐ Chest Pain
- ☐ Chicken Pox
- ☐ Chlamydia
- ☐ Colitis
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ FMS/CFS
- ☐ Gallbladder Disease
- ☐ Glaucoma/Eye Disease
- ☐ Gonorrhea
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Interstitial Cystitis
- ☐ Kidney/Bladder Problems
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Measles
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Mood Changes
- ☐ Mumps
- ☐ Pelvic Inflammatory Disease
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Psychiatric Problems
- ☐ Redness/Pain in Leg
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Syphilis
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Varicose Veins
- ☐ Venereal Warts
- ☐ Other _______________
- ☐ Other________________

Surgical History (check all that apply)

- ☐ Appendix Operation Date: ____________
- ☐ Breast Augmentation Date: ____________
- ☐ Breast Biopsy Date: ____________
- ☐ Bladder Surgery Date: ____________
- ☐ C-Section Date: ____________
- ☐ Coronary Artery Bypass Date: ____________
- ☐ D&C Date: ____________
- ☐ Endometrial Ablation Date: ____________
- ☐ Gallbladder Operation Date: ____________
- ☐ Hemorrhoid Operation Date: ____________
- ☐ Hernia Operation Date: ____________
- ☐ Hip Date: ____________
- ☐ Hysterectomy Date: ____________
- ☐ Laparoscopy Date: ____________
- ☐ Plastic Surgery Date: ____________
- ☐ Removal of Tube or Ovary Date: ________
- ☐ Thyroid Operation Date: ____________
- ☐ Tonsillectomy Date: ____________
- ☐ Tubal Ligation Date: ____________
- ☐ Varicose Vein Operation Date: __________
- ☐ Other _________________________________
- ☐ Other _______________________________

Family History (check all that apply)

Does anyone in your immediate family – mother, father, siblings – have the following conditions(s):

- ☐ Breast Cancer ____________________
- ☐ Bleeding Disorders____________________
- ☐ Cancer, other type____________________
- ☐ Diabetes ____________________
- ☐ Fibrocystic Breast __________________
- ☐ Heart Disease ____________________
- ☐ Osteoporosis ____________________
- ☐ Thyroid Disorder ____________________

Other ____________________ Explain ____
Other ____________________ Explain ____

Social History (check all that apply)

Do you drink caffeinated products? ☐No ☐Yes How many drinks per day/month? ___________

Are you a smoker? ☐No ☐Yes Packs per day? ______________Years smoked? ___________

Are you a former smoker? ☐No ☐Yes Years smoked? ______________Year quit?____________

Do you drink alcohol? ☐No ☐Yes How many drinks per day/month? ___________

Do you exercise? ☐No ☐Yes How many times per week? _________ What type? _________

Do you use recreational drugs? ☐No ☐Yes

Medical Tests (check all that apply)

☐ Mammography Date: _______________ Were the results normal? ☐No ☐Yes

If no what follow-up was needed?____

☐ PAP Smear Date: _______________ Were the results normal? ☐No ☐Yes

If no what follow-up was needed?____

Have you ever had an abnormal pap? ☐No ☐Yes

If yes what follow-up was needed?____

☐ Bone Density Date: _______________ Results:___________________________________

☐ Colonoscopy Date: _______________ Results:___________________________________

Are there any other pertinent medical history concerns we should be aware of?

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Name of any physicians familiar with your medical history:

____

____

Patient Signature_________________________________Date_______________________Provider Initials