

BOULDER WOMEN'S CARE
Health History Survey

The more we know about you, the better we can provide medical care. Please fill out the following items as completely and accurately as possible. If you have a question, please ask one of our staff members. All of the information provided is confidential.

Today's date _____

NAME: _____ AGE: _____

MEDICATIONS (Please include vitamins, herbs, aspirins, birth control pills, etc)

Name of medication	Dosage and Frequency	Length of time on medication

ALLERGIES/REACTION: _____

PERSONAL HISTORY

MAIN PROBLEMS (1) _____
(2) _____
(3) _____

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Decreased Hearing | <input type="checkbox"/> Indigestion/heartburn | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Ear infections-frequent | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood clot |
| <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Tremor | <input type="checkbox"/> Failing Vision |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Anemia | <input type="checkbox"/> Weight loss-recent |
| <input type="checkbox"/> Double or Blurred Vision | <input type="checkbox"/> Constipation | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Headaches-frequent | <input type="checkbox"/> Blood transfusion |
| <input type="checkbox"/> Nose Bleeds-recurrent | <input type="checkbox"/> Bloody/tarry stools | <input type="checkbox"/> Arthritis/rheumatism | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Backpain | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Sore throats-frequent | <input type="checkbox"/> Jaundice/hepatitis | <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Hayfever/Allergies | <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Skin conditions | # per day _____ |
| <input type="checkbox"/> Hoarseness-prolonged | <input type="checkbox"/> Hernia | <input type="checkbox"/> Phobias | # of years _____ |
| <input type="checkbox"/> Pneumonia/Pleurisy | <input type="checkbox"/> Urinary tract infections | <input type="checkbox"/> Mental illness | quit _____ |
| <input type="checkbox"/> Bronchitis/chronic cough | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Drug addictions | daily _____ |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Overnight urination | <input type="checkbox"/> Recreational drug use | 1-2 per wk _____ |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Kidney stones/disease | <input type="checkbox"/> Memory loss | 1-2 per month _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Chicken pox | |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Breast problems | <input type="checkbox"/> Measles | |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Excessive thirst/urination | <input type="checkbox"/> Migraines | <input type="checkbox"/> Mumps | |

GYNECOLOGIC HISTORY

Menstrual pattern:

Age of onset: _____ #Days of flow: _____ Length of cycle: _____

Flow: Light _____ Moderate _____ Heavy _____

Cramps: Light _____ Moderate _____ Severe _____

Birth Control Method Used Now _____ What have you used in the past _____

Age at Menopause (if applicable) _____

History of abnormal pap smears? Yes _____ No _____ If yes, any prior therapy? (ie LEEP, cryotherapy etc) _____

Prior DES exposure? Yes _____ No _____

Date of last pap smear _____ Last bone density scan _____ Last mammogram _____

Over please

PREGNANCY HISTORY (Please include miscarriages and abortions)

D.O.B	Sex	Weight	Vaginal or C/S	Location	Complications

HOSPITALIZATIONS

Year	Illness or operation	Year	Illness or operation

FAMILY HISTORY If any blood relative has suffered any of the following, please indicate which relative.

- | | | |
|---|--|--|
| <input type="checkbox"/> Lung disease _____ | <input type="checkbox"/> Colon cancer _____ | <input type="checkbox"/> Kidney disease _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Breast cancer _____ | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> Migraine _____ | <input type="checkbox"/> Cancer (other) _____ | <input type="checkbox"/> Glaucoma _____ |
| <input type="checkbox"/> Mental illness _____ | <input type="checkbox"/> Osteoporosis _____ | <input type="checkbox"/> Alcoholism _____ |
| <input type="checkbox"/> Gallstones _____ | <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Bleeding disorders _____ |
| <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Gastrointestinal problems _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Thyroid disease _____ | <input type="checkbox"/> Other _____ |

	Age if living	Age at death / Cause
Father		
Mother		
Brothers		
Sisters		
Spouse		
Children		

MARRIED _____ **SINGLE** _____ **WIDOW** _____ **DIVORCED** _____ **PARTNER** _____

OCCUPATION: _____

CAFFEINE (what products, how much, etc): _____

DIET (special diet, vegetarian, etc): _____

CALCIUM INTAKE (what products, how much, etc): _____

EXERCISE (what type, how often, how long, etc): _____

SELF BREAST EXAMS (how often do you do your own breast exams, etc): _____

REFERRED BY: _____

Thank you for completing this form.

Reviewed by: _____

Date: _____

