Confidential Health History

Women's Specialists of New Mexico, Ltd.

Welcome to Women's Specialists of New Mexico. Please complete the following questions to allow us to provide you with the best health care. If you do not understand any question or do not want to answer any question, leave it blank. All answers will be confidential and will be reviewed with your provider.

(505) 843-6168 **www.wsnm.org**

Updated 12/09/10

Name:	Age:	Birth Date:

What would you like to be called, if different from above?	How were you referred to our office? ☐ Yellow Pages ☐ Family / Friend ☐ Other: ☐ Insurance ☐ Physician

Referring Physician / Person:	Today's Date:

Primary Care Provider:	Would you like a chaperone for your exam today? ☐ Yes ☐ No

Please describe any special problems or symptoms that you would like to discuss.

PREVENTIVE HEALTH

	Date of last:		Date of last:		Date of last:
Pap		Dental Exam		Bone Density	
Mammogram		Eye Exam		Breast Cancer Gene	☐ Yes ☐ No
Blood Work		Colonoscopy			

MEDICAL HISTORY

Please check any past or current medical problems for yourself or immediate, blood relative. **Grandparents:**

X = Yourself M = Mother F = Father S = Sister B = Brother Maternal = MGM or MGF Paternal = PGM or PGF

	You	Family		You	Family
Autoimmune Disease (Lupus, MS, etc.)			Heart Disease		
Alzheimer's			Hemorrhoids		
Anemia			Hepatitis		
Arthritis			High Blood Pressure		
Bleeding Disorder			Irritable Bowel Syndrome		
Blood Clots in legs			Kidney Disease		
Blood Clots in lungs			Lung Disease, Asthma		
Blood Disorders			Mental Illness, Depression		
Cancer Breast			Migraine Headache		
Cancer Colon			Osteoporosis		
Cancer Ovarian			Seizure Disorder		
Cancers Other			Skin Disorders		
Diabetes			Stroke		
Drug/Alcohol Abuse			Thyroid Disorder		
Frequent Bladder Infections			Tuberculosis		
Gallbladder Disease or Gallstones			Ulcers		
Hearing Problems			Other:		

SURGERIES

Date:	Surgery:	Date:	Surgery:

HOSPITALIZATIONS (Non-Surgical)

Date:	Problem / Diagnosis:	Comments:

CURRENT MEDICATION

List any MEDICATIONS you are taking, to include birth control pills, Tylenol, Advil, Aspirin, other non-prescription medicine, vitamins, herbs.

Medication Name	Dose	Frequency of Dose	Medication Name	Dose	Frequency of Dose

Do you take Calcium?	☐ Yes ☐ No	If yes, amount:	
Do you take Vitamin D?	☐ Yes ☐ No	If yes, amount:	
Do you take a Multiple vitamin or Prenatal Vitamin?	☐ Yes ☐ No		

Name:	DOB:	Date:

MEDICATION ALLERGIES

Do you have any medication allergies? ☐ Yes ☐ No	If yes, to what?	What type of reaction do you have?

FOOD ALLERGIES

Do you have any food allergies? ☐ Yes ☐ No	If yes, to what?	What type of reaction do you have?

ENVIRONMENTAL / LATEX ALLERGIES

Do you have any environmental / latex allergies? ☐ Yes ☐ No	If yes, to what?	What type of reaction do you have?

MENSTRUAL HISTORY

First day of last normal menstrual period - Date:	Is menstrual pain or cramping a problem for you? ☐ Yes ☐ No
Age period began:	Do you ever have spotting or bleeding in between your periods: ☐ Yes ☐ No
Number of days between periods:	
Length of periods (# of days of bleeding):	Is PMS a problem for you? ☐ Yes ☐ No
Menstrual flow: ☐ Light ☐ Medium ☐ Heavy	Do you perform self breast exams? ☐ Yes ☐ No

How often do you change pads / tampons on your heaviest day of menses? Every _____ hours

Method of birth control:

☐ Condoms	☐ Diaphragm	☐ Implanon	☐ Nuva Ring	☐ Post Menopause	☐ Vasectomy
☐ Contraceptive Pills	☐ Essure	☐ IUD	☐ Foam, Jelly, etc	☐ Same Sex Partner	☐ Other:
☐ Depo Provera	☐ Hysterectomy	☐ Not Sexually Active	☐ Patch	☐ Tubal Ligation	☐ None

Are you interested in a different method of birth control? ☐ Yes ☐ No

REPRODUCTIVE PREGNANCY HISTORY

# of times pregnant:	# of term deliveries:	# of deliveries prior to 37 weeks:	# of elective abortions:
# of miscarriages:	# of ectopic pregnancies:	# of multiple births:	# of living children:

PREGNANCY DETAILS # 1

Date:	Type of delivery:	Complications:
# weeks at delivery:	☐ Vaginal	
Birth weight:	☐ C-section	
Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage	

PREGNANCY DETAILS # 2

Date:	Type of delivery:	Complications:
# weeks at delivery:	☐ Vaginal	
Birth weight:	☐ C-section	
Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage	

PREGNANCY DETAILS # 3

Date:	Type of delivery:	Complications:
# weeks at delivery:	☐ Vaginal	
Birth weight:	☐ C-section	
Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage	

PREGNANCY DETAILS # 4

Date:	Type of delivery:	Complications:
# weeks at delivery:	☐ Vaginal	
Birth weight:	☐ C-section	
Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage	

SOCIAL HISTORY

Marital Status: ☐ Divorced ☐ Engaged ☐ Married ☐ Partnered ☐ Separated ☐ Single ☐ Widowed

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American Tribe: ☐ Other:

Education: ☐ High School Graduate / GED ☐ Junior College / College / Trade School ☐ Post Graduate

Patient Occupation:	Husband / Partner's Occupation:

Do you exercise? ☐ Yes ☐ No If yes, # of times per week:	Number of children living at home:	Is your diet nutritionally balanced? ☐ Yes ☐ No

Do you / did you ever drink alcohol? ☐ Yes ☐ No	How much per week?	How many drinks a day?	Is alcohol or drug use a problem for you? ☐ Yes ☐ No

Do you / did you ever use tobacco? ☐ Yes ☐ No	If Yes, what type? ☐ Chewing Tobacco ☐ Smoking / Cigarettes	For how many years?	How much per day?	When did you stop? Date:

Do you / did you ever use any recreational drugs or abuse prescription drugs? ☐ Yes ☐ No	If Yes, what type?

☐ Yes ☐ No Have you ever been sexually abused?	☐ Yes ☐ No If you have experienced abuse, have you received counseling?
☐ Yes ☐ No Have you ever been physically abused?	
☐ Yes ☐ No Have you ever been emotionally abused by anyone important to you?	☐ Yes ☐ No Is this something you would like to discuss today?

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Name:	Date of Birth:	Today's Date:

REPRODUCTIVE PREGNANCY HISTORY (continued)

PREGNANCY DETAILS # 5			**PREGNANCY DETAILS # 6**		
Date:	Type of delivery:	Complications:	Date:	Type of delivery:	Complications:
# weeks at delivery:	☐ Vaginal		# weeks at delivery:	☐ Vaginal	
Birth weight:	☐ C-section		Birth weight:	☐ C-section	
Sex of child:	☐ Elective abortion		Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage		Name:	☐ Miscarriage	
PREGNANCY DETAILS # 7			**PREGNANCY DETAILS # 8**		
Date:	Type of delivery:	Complications:	Date:	Type of delivery:	Complications:
# weeks at delivery:	☐ Vaginal		# weeks at delivery:	☐ Vaginal	
Birth weight:	☐ C-section		Birth weight:	☐ C-section	
Sex of child:	☐ Elective abortion		Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage		Name:	☐ Miscarriage	
PREGNANCY DETAILS # 9			**PREGNANCY DETAILS # 10**		
Date:	Type of delivery:	Complications:	Date:	Type of delivery:	Complications:
# weeks at delivery:	☐ Vaginal		# weeks at delivery:	☐ Vaginal	
Birth weight:	☐ C-section		Birth weight:	☐ C-section	
Sex of child:	☐ Elective abortion		Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage		Name:	☐ Miscarriage	
PREGNANCY DETAILS # 11			**PREGNANCY DETAILS # 12**		
Date:	Type of delivery:	Complications:	Date:	Type of delivery:	Complications:
# weeks at delivery:	☐ Vaginal		# weeks at delivery:	☐ Vaginal	
Birth weight:	☐ C-section		Birth weight:	☐ C-section	
Sex of child:	☐ Elective abortion		Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage		Name:	☐ Miscarriage	

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Name:	Date of Birth:	Today's Date:

GYN HISTORY

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

If so, how was it treated? ☐ Given medication ☐ Colposcopy ☐ Leep ☐ Cone Biopsy ☐ Repeat pap ☐ Biopsy ☐ Cryotherapy ☐ Hysterectomy

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

If so, how was it treated? ☐ Repeat mammogram ☐ Breast Biopsy ☐ Other

☐ Yes ☐ No Have you been sexually active in the last year?

Are you sexually active with ☐ Males ☐ Females ☐ Both

☐ Yes ☐ No Have you had a new sexual partner in the last year?

☐ Yes ☐ No Do you have pain with intercourse?

☐ Yes ☐ No Do you have bleeding with or after intercourse?

☐ Yes ☐ No Do you have any concerns about sexual relations?

☐ Yes ☐ No Have you been diagnosed with a female infection?

If yes please indicate: ☐ Trichomonas ☐ Gonorrhea ☐ Chlamydia ☐ Syphilis ☐ Chronic Yeast Infection ☐ Bacterial Vaginosis ☐ Vaginal Herpes ☐ Vaginal Warts / HPV

☐ Yes ☐ No Would you like to be tested for HIV/AIDS?

☐ Yes ☐ No Would you like to be tested for sexually transmitted infections?

☐ Yes ☐ No Have you had a recent major stress (e.g., loss of job, loss of loved one, change in marital status, other)?

☐ Yes ☐ No Do you feel safe in your home?

☐ Yes ☐ No Have you ever had an infertility problem or difficulty getting pregnant?

☐ Yes ☐ No Do you have any problems with bladder or bowel control?

MENOPAUSE / PERIMENOPAUSE SYMPTOMS

☐ Yes ☐ No Do you have any of the following menopause or perimenopausal symptoms?

☐ Hot Flashes ☐ Vaginal Dryness ☐ Night Sweats ☐ Difficulty Sleeping

☐ Yes ☐ No Are you using any non-medical treatments for the above symptoms?

If so, please list:

☐ Yes ☐ No If you are using hormone replacement therapy, are you satisfied with it?

☐ Yes ☐ No Are you interested in alternative therapies?

VERIFICATION

Form Completed By:	Patient Signature:
☐ Patient ☐ Medical Assistant ☐ Physician _____ ☐ Office Nurse (name or initials)	
Date Reviewed By Physician With Patient:	Physician Signature: