Women's Integrative Health
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PATIENT HISTORY

Please fill out as thoroughly as you can.

LMP:_____
EDC:_____
EGA:_____

Date Today:_________________

(First) (Middle) (Last)
Name:____
Age:_______
Date of Birth:_____________________ Place of Birth:__________________________
Ethnicity:____
Religious/Cultural Considerations:_____________________________________
Referred by:____
Emergency Contact:__________________ Relationship:__________ Phone:_________

Chief Reason for Today's Visit:
____
____
____
____

Past Obstetric History:

Any history of INFERTILITY problems?_____________________________________
Total Number of Pregnancies to date:_____
Total Number of full-term pregnancies delivered (near to due date)_______
Total Number of pre-term deliveries (before 37 weeks of pregnancy)______
Total Number of elective terminations:_______
Total Number of Ectopic pregnancies:_______
Total Number of Spontaneous Miscarriages:_______
Total Number of Twin/Multiple Pregnancies:______
Total Number of Living Children Currently:_______

Details of Pregnancies:

Year Delivered	Length of Pregnancy	Duration of labor	Type of Delivery (Vag. Or C-section)	Infant (Sex/Wt.)	Complications D&C?,Now living?
1.					
2.					
3.					
4.					
5.					

NAME:______________________

Past Gynecological History:

Date of last menstrual period:__________________ Are you sure of this date?___
Age when first menstrual period began :__________
Last Pap Smear:_________ Was it normal?______ Where done:_____________
Last Breast Exam by a Dr.______________________ Normal ?____________
Last Mammogram:___________ Was it normal?______ Where done:_______________

My Menstrual Periods are: (Circle one)
REGULAR (once a month) or IRREGULAR (more or less than once a month)

The interval between the onset of one period to the onset of the next is____ days.
Duration of menstrual flow is______ days.
Is the menstrual flow (circle one) Mild Moderate Heavy Severe
Do you have problems with bleeding in between periods?________________
Are menstrual periods painful?______ If yes,(circle one): mild moderate severe
What do you take(or have you taken) for pain?_____________________________
Is intercourse usually painful?____
Have you ever been told you have endometriosis?__________________________
Do you get PMS (pre-menstrual syndrome) symptoms?__________
Circle symptoms that you get right before you period:
Headaches frequent urination hot flashes breast tenderness
Nightsweats anxiety irritability depression
Bloating other:_______________________________________
Are your PMS symptoms: (circle one) mild moderate severe

Have you has any sexually transmitted disease in your life? (circle below)
Gonorrhea Chlamydia Syphilis herpes HIV
Trichomonas Genital Warts Pelvic Inflammatory Disease

Have you ever been tested for HIV?____ When was last test?________________
Are you bothered by vaginal discharge?_____ Foul-smelling?___ Itching?____

Ever had an abnormal pap smear result?_______ Explain, if yes____________________
____
Have any procedures been performed on your cervix?______________________
What types of contraception have you and your partner(s) used in the presnt/past?
Diaphragm Condom IUD Tubal ligation Vasectomy
Depo-provera shot Norplant Spermicides
Birth Control Pills: (list names) ________________________________
____
Did your mother take DES (diethylstilbestrol) during her pregnancy with you?_______

NAME:_________________________

Past Medical History:

Have you ever been Hospitalized?____
Have you ever had a blood transfusion?____
Have you had chickenpox?__________________________
What medical problems have you had in your life? (Circle)

Anorexia Bulemia High Blood Pressure High Cholesterol Diabetes
Asthma Allergies Frequent Urinary Infections Heart Disease
Frequent Vaginal Infections Kidney Infections
Lung Disorders Hypothyroidism Hyperthyroidism
Liver Disease Cancer Osteoperosis
Depression Strokes Anxiety
Panic Attacks Suicide thoughts, attempts, or plans Trauma/Accidents
Epilepsy Mitral valve prolapse Other

Past Surgical History:

Date of Operation	Type of Surgery	Hospital	Physician	Complications

Medications or Vitamins/Minerals (currently taking)

____
____
____
____

Are you ALLERGIC to any medications?

Medications	What is the reaction when you take it?

Social History:

Do you use Tobacco?__________ How much daily?______________________
Do you drink Alcohol?_________ How much weekly?____________________
Have you ever used recreational drugs?____________________________________
If yes, which ones?____
(marijuana cocaine heroine amphetamines LSD PCP others)

Marital Status: (circle one) Married Single Divorced Seperated
Living together Widowed

Are you currently sexually active?____
Occupation:____________________________________

NAME:___________________

Family History:

Has anyone in your family has any of these diseases or other important diseases?
(List family member next to the associated disease(s)

1. Heart Disease
2. Cancer
   a) Breast Cancer
   b) Colon Cancer
   c) Uterine Cancer
   d) Ovarian Cancer
   e) Cervical Cancer
   f) Other Cancers
3. Osteoperosis
4. Diabetes (with or without insulin)
5. High Blood Pressure
6. Mental Retardation
7. Birth Defects (for example, spina bifida, cystic fibrosis, cleft palate)
8. Genetic Disease (for example: Tay-Sachs trait)
9. Psychiatric disorders (for example, alcoholism, depression, etc.)
10. Tuberculosis
11. Other family diseases?

Symptom Review: (Circle any that apply to you)

Urine loss with cough or strain
Burning with urination
Vaginal discharge, with itching or foul odor
Fever
Night sweats
Chills
Milky or bloody breast discharge
Acne
Blood in stool or hemorrhoids
Frequent backaches
Recent weight change
Poor tolerance to cold temperatures
Bleed or bruise easily
Hot flashes
Insomnia

Constipation
Diarrhea
Nausea/vomiting
Frequent headaches
Chest pain
Shortness of breath
Excess hair growth
Hair Loss
Blood in Urine
Depression
Anxiety or Panic attacks
Dry Skin
Decreased sex drive
Vaginal dryness

Other:____