Patient Centered Care, PLL-C
FEMALE HEALTH HISTORY

Name: _____ **Age** _____ **Date of Birth** _____

Living Situation: Spouse _____ Alone ____ Partner _____ Friend(s) ____ Parents ____ #Children ____ Other _____

What is the reason for your visit today? If it is a problem, please describe the symptoms & be specific: _____
_____
_____

Please list any allergies you have to food or medications: _____

Please list any medical problems that you are currently being treated for or have been treated for in the past: _____
_____
_____

Please list any surgeries that you have had including the date: _____
_____
_____

Please list any medications, prescription or over-the-counter, that you take: _____
_____
_____

Do your parents have any of the following? (Check all that apply)
___ Diabetes ___ Heart Attack ___ Cancer If so, what type? _____ ___ Stroke
___ High Cholesterol ___ High Blood Pressure ___ Blood clots ___ Heart disease/heart surgery
Do your grandparents have any of the following? (Check all that apply)
___ Diabetes ___ Heart Attack ___ Cancer If so, what type? _____ ___ Stroke
___ High Cholesterol ___ High Blood Pressure ___ Blood clots ___ Heart disease/heart surgery
Do your sister/brothers have any of the following? (Check all that apply)
___ Diabetes ___ Heart Attack ___ Cancer If so, what type? _____ ___ Stroke
___ High Cholesterol ___ High Blood Pressure ___ Blood clots ___ Heart disease/heart surgery

Age of first period: ____ Date of last period: _____ Date of last Pap smear: _____ Result: _____

If you are still having a period, what is your method of contraception? _____

Are you sexually active? ____ YES ____ NO With males, females, or both? _____

Date of last mammogram: _____ Result: _____ Date of last bone density study: _____ Result: _____

Date of last sigmoidoscopy/colonoscopy: _____ Result: _____

Do you get routine physical exercise? ___ YES ___ NO If yes, what type & how long? _____

Do you smoke cigarettes? ___ YES ___ NO If yes, # per day: _____ Age started: _____

Previous smoker? ___ YES ___ NO Age stopped: _____ Pack per day: _____ # of years: _____

Do you drink alcohol? ___ YES ___ NO If yes, how much per day? _____ What type? _____

Do you drink caffeine products? ___ YES ___ NO If yes, how much per day? _____ What type? _____