Oregon Health & Science University
Hospitals and Clinics

CENTER for WOMEN'S HEALTH

INITIAL HEALTH HISTORY AND ASSESSMENT

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

Name: _____ **Birth date:** _____ **Today's date:** _____
Last First Middle mo / day / yr mo / day / yr

Phone number: Home:_____ **Work:** _____**Age:**_____ **Primary Care Provider:** _____

Why are you coming to the Center today? _____

_____

Past Medical and Family History

For yourself, provide details and dates. For family members, please check if yes.

	Self	Mother	Father	Siblings	Children	Other
Stroke						
Heart Disease						
Hypertension						
High Cholesterol						
Asthma/emphysema						
Thyroid disease						
Diabetes						
Cancer Type						
Alcoholism						
Drug Abuse						
Osteoporosis						
Arthritis						
Heartburn/ulcer						
Bowel problems						
Depression / Anxiety						
Hepatitis						
Eating Disorders						

Other health issues?_____

_____

List any surgeries you have had

Description **Date**

_____

_____

_____

_____

_____

_____

_____

_____

OC1202

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Gynecologic / Obstetric History

Age of first period _____

Date of last menstrual period ____/____/_____

How many days between periods (average)? _____

How long do periods last? _____

Bleeding between periods? Yes ☐ No ☐

Bleeding after menopause? Yes ☐ No ☐

Are periods too heavy/too painful? Yes ☐ No ☐

Contraception? Yes ☐ No ☐ Type: _____

Are you sexually active? Yes ☐ No ☐
With: Man ☐ Woman ☐ Both ☐

Do you have sexual concerns? Yes ☐ No ☐

Is intercourse painful? Yes ☐ No ☐

New sexual partner in the last year? Yes ☐ No ☐

Number of lifetime sexual partners:
less than 5 ☐ 5 or more ☐

Number of pregnancies _____
Vaginal deliveries _____
C-sections _____
Miscarriages _____
Abortions _____

Date of Last Pap: ____/____/_____

History of abnormal Pap smears? Yes ☐ No ☐

History of sexually transmitted infections? Yes ☐ No ☐

If so, type(s)
_____

History of sexual or physical abuse? Yes ☐ No ☐

Current sexual or physical abuse? Yes ☐ No ☐

Do you perform self breast exams? Yes ☐ No ☐

Current medications (prescribed or over the counter) / supplements / herbs

Medication / Dose	Medication / Dose	Medication / Dose

List allergies to medications including reaction

Medication / Reaction	Medication / Reaction

Social history and habits:

Single ☐ Partnered ☐ Married ☐ Divorced / separated ☐ Widowed ☐

Do you work outside the home? Yes ☐ No ☐

What is your occupation? _____

Do you have children? Yes ☐ No ☐ Ages _____

Do you exercise? Yes ☐ No ☐ Type/frequency _____

Alcohol use: Yes ☐ No ☐ Amount per day/week _____

Tobacco use: Yes ☐ No ☐ Past use: ☐ Yes ☐ No
cigarettes per day _____ Age began _____ Age quit _____

Drug use: Yes ☐ No ☐ Type: _____

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Do you have any of the following symptoms currently?

- ☐ Abdominal or pelvic pain
- ☐ Constipation / diarrhea / blood in stool
- ☐ Heartburn / trouble swallowing
- ☐ Urine leakage
- ☐ Vaginal / vulvar itching, irritation, discharge
- ☐ Breast lumps / nipple discharge
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Visual / hearing problems
- ☐ Weight loss, fevers, chills, sweats
- ☐ Headaches – migraine or tension
- ☐ Numbness / tingling / weakness of extremities
- ☐ Joint / muscle pain
- ☐ Depression, anxiety, irritability, trouble sleeping
- ☐ Hot flashes / vaginal dryness
- ☐ Other concerns?_____

Screening/Health Maintenance

	Date of last exam/immunization	**RESULT** Normal	Abnormal
Pap Smear			
Mammogram			
Bone Density Exam			
Cholesterol Test			
Diabetes Test			
Thyroid Test			
Self Breast Exam			
Colon Cancer Screening			
Stool cards			
Flexible Sigmoidoscopy			
Colonoscopy			
Barium enema			
Immunizations			
Tetanus			
Hepatitis A			
Hepatitis B			
Measles/Mumps/ Rubella			
Influenza			
Pneumonia			

Assessment Completed by:_____ **Date:**_____

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- THIS PAGE FOR THE DOCTOR / PROVIDER TO COMPLETE -

Clarifying Comments:_____

Assessment Reviewed by:_____ **Date:**_____
Resident

_____ **Date:**_____
Attending Faculty