Oregon Health & Science University
Hospitals and Clinics

CENTER *for* WOMEN'S HEALTH

RETURN VISIT
HEALTH HISTORY UPDATE

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

Name: _____ **Age:** _____ **Primary Care Provider:** _____
Last First Middle

Date: _____ **Referring Provider:** _____

Why are you coming to the Center today? _____

_____

What issues do you hope to discuss today? _____

_____

_____

_____

_____

_____

_____

_____

_____

Interval History Since Your Last Visit.

New Health Problems / Surgeries since last visit: _____

_____

_____

_____

New Important Family History:

_____

_____

New Social Circumstances / Habits:

_____

_____

Gynecologic / Obstetric History

Contraception? Tubal? _____ Vasectomy? _____

Date of last menstrual period ____/____/_____

How many days from start to start of 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 ☐

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

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

History of sexual or physical abuse? Yes ☐ No ☐

Current sexual or physical abuse? Yes ☐ No ☐

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

HPV risk:

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

Date of Last Pap: ____/____/_____

History of abnormal Pap smears? Yes ☐ No ☐

History of sexually transmitted infections? Yes ☐ No ☐

If so, type(s) _____

Do you perform self breast exams? Yes ☐ No ☐

OC1202

- continued on reverse -

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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: _____

Do you have any of the following symptoms currently? (Check and circle or underline)

- ☐ 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
- ☐ Do you have sexual concerns
- ☐ 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
- ☐ Is intercourse painful?
- ☐ Other concerns? _____

Screening/Health Maintenance Especially Since Your Last Visit.

	Date of last testing, evaluation	RESULT Normal	Abnormal
Pap Smear			
Mammogram			
Bone Density Exam			
Cholesterol Test			
Diabetes Test			
Thyroid Test			
Colon Cancer Screening			
Stool cards			
Flexible sigmoidoscopy			
Colonoscopy			
Barium enema			

Reviewed by: _____ Date: _____