Dr. Randolph's Ageless & Wellness Medical Center
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FEMALE HEALTH HISTORY FORM

(Please Print Clearly)

Date: ________________

Name: ____ DOB: ________________

Reason for today's visit: ____
____

Gynecological History

Age of menstrual period onset ________________

Date of last period________________________

How long did it last? _______________________

Are your periods generally regular? ☐No ☐Yes

Do you bleed between periods? ☐No ☐Yes

Do you or did you ever have PMS? ☐No ☐Yes

Method of birth control used __________________

Do you bleed after intercourse? ☐No ☐Yes

Date of last pap smear _____________________

Were the results normal? ☐No ☐Yes

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

If yes, what follow-up was needed? ____________
____

When was your last mammogram? ____________

Were the results normal? ☐No ☐Yes

If no, what follow-up was needed? ____________
____

Do you desire STD testing? ☐No ☐Yes

Do you have sexual concerns? ☐No ☐Yes

Do you have any problems with leaking urine or have incontinence concerns? ☐No ☐Yes

Pregnancies

How many pregnancies have you had? __________

How many miscarriages? ___________________

How many children were born alive? __________

How many abortions? ______________________

How many tubal pregnancies? _______________

Any complications with pregnancy? ☐No ☐Yes

Explain_________________________________
____
____

Menopause

At what age did your periods stop? __________

Have you had a hysterectomy? ☐No ☐Yes

If yes, when? ____________________________

Do you have your ovaries? ☐No ☐Yes

Allergies (check all that apply)

__Aspirin

__Betadine

__Codeine

__Latex

__Novocain

__Sulfa

__Shellfish

__Other ________________________________
____

Weight

Usual: __________ Recent Gain: __________ Recent Loss: __________

Personal Medical History (check all that apply)

__Anemia
__Arthritis/Gout
__Asthma
__Blood Clots
__Blood Transfusion
__Blurred Vision
__Bronchitis
__Cancer / type: _____________
__Chest Pain
__Chicken Pox
__Chlamydia
__Colitis
__Depression
__Diabetes
__Emphysema
__Endometriosis
__Epilepsy
__FMS/CFS
__Gallbladder Disease
__Glaucoma/Eye Disease
__Gonorrhea
__Headaches
__Heart Attack
__Heart Disease
__Heart Murmur
__Hepatitis
__Herpes
__High Blood Pressure
__Interstitial Cystitis
__Kidney/Bladder Problems
__Liver Disease
__Lung Disease
__Measles
__Migraines
__Mononucleosis
__Mood Changes
__Mumps
__Nervous / Mental Disorder
__Pelvic Inflammatory Disease
__Phlebitis
__Pneumonia
__Psychiatric Problems
__Redness/Pain in Leg
__Rheumatic Fever
__Shortness of Breath
__Stroke
__Syphilis
__Thyroid Problem
__Tuberculosis
__Ulcer
__Varicose Veins
__Venereal Warts
__Other _________________
____

Medical Tests (check all that apply)

__Mammography (Date: _______________)
__PAP Smear (Date: _______________)
__DEXA (Date: _______________)
__Colonoscopy (Date: _______________)
__Cholesterol (Date: _______________)

Surgical History (check all that apply)

__Appendix Operation (Date: _______________)
__Breast Biopsy (Date: _______________)
__Bladder Surgery (Date: _______________)
__C-Section (Date: _______________)
__D&C (Date: _______________)
__Endometrial Ablation (Date: _______________)
__Gallbladder Operation (Date: _______________)
__Hemorrhoid Operation (Date: _______________)
__Hernia Operation (Date: _______________)
__Hysterectomy (Date: _______________)
__Laparoscopy (Date: _______________)
__Plastic Surgery (Date: _______________)
__Removal of Tube or Ovary (Date: _____________)
__Thyroid Operation (Date: _______________)
__Tonsillectomy (Date: _______________)
__Tubal Ligation (Date: _______________)
__Varicose Vein Operation (Date: _______________)
__Other _____________________________________
____

X-Rays (check all that apply)

__Chest	__Lower GI	__Skull
__Stomach/Esophagus	__Gallbladder	__Colon
__Upper GI	__Kidneys	

Social History (check all that apply)

Do you drink caffeinated products? ☐No ☐Yes How many drinks per day/month? ___________

Are you a smoker? ☐No ☐Yes Packs per day? ___________ Years smoked? ___________

Do you drink alcohol? ☐No ☐Yes How many drinks per day/month? ___________

Do you exercise? ☐No ☐Yes How many times per week? __________ What type? ______________

Do you use drugs? ☐No ☐Yes

Family History (check all that apply)

Does anyone in your immediate family – mother, father, siblings – have the following conditions(s):

Condition	Whom	
__Breast Cancer	____________________	
__Bleeding Disorders	____________________	
__Cancer, other type	____________________	
__Diabetes	____________________	
__Fibrocystic Breast	____________________	
__Heart Disease	____________________	
__Osteoporosis	____________________	
__Thyroid Disorder	____________________	
__Other	____________________	Explain ____
__Other	____________________	Explain ____

Are there any other pertinent medical history concerns we should be aware of?

____

____

Name of any physicians familiar with your medical history:

____

____

____

Patient Signature Date Provider Initials