Foothill Family Clinic

PATIENT HISTORY FOR FEMALE HEALTH MAINTENANCE EXAM

Name:_____Birthdate:____/____/_____ Today's date:____/____/_____

Please list all **Prescription Medications/Over-the-counter/Vitamins/Supplements** you are currently taking:

Medication Name	Strength	Frequency	Reason for medication	Refill needed?
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N

List any **Medication Allergies** you may have:

Medication:	Reaction:
_____	_____
_____	_____

SOCIAL HISTORY

Education Level:_____
Occupation:_____ Retired No Yes Occupational hazards? _____
Marital Status: Married Single Divorced Widowed Life Partner Other:_____
Who lives in your home? Live Alone Spouse Children:_____ Father Mother Other:_____
Do you use Tobacco? Never Current user Former user Type: Cigarettes Chew Pipe Other:_____
Units/day: .5 1 1.5 2 Other:_____ Years used: _____Years quit:_____
Do you drink Alcohol? No Yes Formerly How many drinks per week? 1-3 4-6 7-10 Other:_____
Do you drink Caffeine? No _ Yes Type of Caffeine: Soda Coffee Energy drinks Other:_____ Amount/day:_____

LIFESTYLE

Type of exercise: _____ _____ _____ _____
Exercise Frequency: 2-3 times/week 3-4 times/week Daily Never Occasionally Hours/week: 0-5 5-10 10-15

Do you have a religious affiliation Y N Religion:_____ Is religion/spirituality an important part of your life? Y N
Do you practice your religion? Y N Do you agree to transfusion? Y N

HOME ENVIRONMENT/SAFETY

Do you have smoke detectors in your home? Y N Pool/ spa at home? Y N
Do you have carbon monoxide detectors in your home? Y N Type of home heating? Gas Coal Electric Solar
Falls in the last year? Y N Number of falls: _____ Radon in the home? Y N
Firearms at home? Y N Number of firearms? _____ Locked storage? Y N
Do you use a seatbelt in the car? Always Never Occasionally
Do you have pets? What kind? _____

HEALTH MAINTENANCE

Date of last checkup: ____/____/_____ Please check one of the following: Premenopausal Perimenopausal Postmenopausal
Date of last menstrual period: _____/_____/_____ Hysterectomy? Y N Year: _____
How many times have you been **pregnant**? _____ Number of live births? _____ Age at first birth? _____
What are you doing to prevent pregnancy?_____
Have you ever had a sexually transmitted disease? Y N If so, which one?_____
What are you doing to prevent getting HIV or a sexually transmitted disease? _____
Date of last **Pap smear**: ____/____/_____ Have you ever had an **abnormal pap**? Y N Date of last **Mammogram**: ____/____/____
Have you ever had a **Colonoscopy**? Y N Date:_____ How many glasses of milk do you drink a day? 1 2 3 5 6+
Have you ever had a **Dexa Scan**? Y N Date:_____ Have you ever had your Cholesterol Checked? _Y N Date:_____
Enter the most recent dates of the following immunizations:
Tetanus_____ Pneumonia_____ Flu_____ Hepatitis B_____ Hepatitis A_____ MMR_____ Shingles_____

Continued on back side →

PAST MEDICAL HISTORY

Please list all the Surgeries or Hospitalizations you have had:

Surgery or Reason for Hospitalization	Date	Hospital/City
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all current Medical Conditions or Illnesses for which you are being treated or followed by a physician:

Condition or Diagnosis	Date of Onset	Physician or Location
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any other significant Past Illnesses or Injuries from which you have completely recovered:

Injury/Illness/Diagnosis	Date
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

			Which Family Members?				Which Family Members?
Alzheimer's Disease	Y	N	_____	High Cholesterol	Y	N	_____
Asthma	Y	N	_____	High Blood Pressure	Y	N	_____
Blood Disease	Y	N	_____	Mental Illness	Y	N	_____
Depression	Y	N	_____	Migraines	Y	N	_____
Cancer/Type	Y	N	_____	Osteoarthritis	Y	N	_____
CVA (stroke)	Y	N	_____	Osteoporosis	Y	N	_____
Diabetes	Y	N	_____	Heart Disease	Y	N	_____
				Other:_____	Y	N	_____

REVIEW OF SYSTEMS

Circle any item that relates to your current state of health: **(Leaving an item unmarked indicates a NEGATIVE response)**

GENERAL HEALTH
Chills
Fatigue
Fever
Malaise
Night Sweats
Weight Gain
Weight Loss
Other:
Exercise Intolerance
Change in Appetite
Irritability

HEENT
Ear Drainage
Ear Pain
Eye Discharge
Eye Pain
Hearing Loss
Nasal Drainage
Sinus Pressure
Sore Throat
Visual Changes
Other:
Difficulty Swallowing
Double Vision
Jaw Pain
Mouth Ulcers
Ringing in Ears
Sensitivity to Light
Snoring
Tooth Pain

RESPIRATORY
Chronic cough
Cough
Known TB exposure
Shortness of breath
Wheezing
Other:
Apnea
Asthma
Coughing Blood
Painful Respirations
Respiratory Infections
Trouble Breathing

CARDIOVASCULAR
Chest Pain
Leg Pain w/ Walking
Edema
Palpitations
Other:
Irregular Heart Beat
Loss of Consciousness
Tingling in Extremity

GASTROINTESTINAL
Abdominal Pain
Blood in Stools
Change in Stool
Constipation
Diarrhea
Heartburn
Loss of Appetite
Nausea
Vomiting
Other:
Acid Reflux
Fecal Incontinence
Hemorrhoids
Rectal Bleeding

GENITOURINARY
Painful Urination
Blood in Urine
Excessive Urination
Urinary Frequency
Urinary Incontinence
Urinary Retention
Other:
Flank Pain
Foul Urine Odor
Kidney Stones
Recurrent UTI

REPRODUCTIVE
Abnormal pap
Painful menstruation
Painful intercourse
Hot flashes
Irregular menses
Vaginal discharge
Other:
Fibroids
Genital lesions
Infertility
Ovarian cysts
Vaginal dryness
Vaginal itching

INTEGUMENTARY
Breast Discharge
Breast Lump
Brittle Hair
Brittle Nails
Hair Loss
Excessive Hairiness
Hives
Itching
Mole changes
Rash
Skin lesion
Other:
Acne
Eczema
Skin infection

NEUROLOGICAL
Dizziness
Extremity Numbness
Extremity Weakness
Gait Disturbance
Headache
Memory Loss
Seizures
Tremors
Other:
Altered Mental Status
Confusion/Disorientation
Facial Droop
Focal Weakness
Frequent Falls
Speech Changes
Trouble Speaking

PSYCHIATRIC
Anxiety
Depression
Insomnia
Other:
Behavior Changes
Difficulty Concentrating
Difficulty Sleeping
Excessive Stress
Problems Coping
Suicidal Thoughts

METABOLIC/ ENDOCRINE
Cold Intolerance
Heat Intolerance
Excessive Thirst
Excessive Hunger
Other:
Excessive Perspiration
Growth Delay

MUSCULOSKELETAL
Back Pain
Joint Pain
Joint Swelling
Muscle Weakness
Neck Pain
Other:
Arthritis
Osteoporosis

HEMATOLOGIC/ LYMPHATIC
Easy Bleeding
Easy Bruising
Swollen Lymph Nodes

IMMUNOLOGIC
Contact Allergy
Environmental Allergies
Food Allergies
Seasonal Allergies